THE MODERN HOSPITAL

A Monthly Journal Devoted to the Construction, Equipment, Administration and Maintenance of Hospitals and Sanatoriums.

VOL. XXXVIII May, 1932 NUMBER 5

Dangers in the Use of Compressed Gas and How to Avoid Them

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WE wish to call attention to certain dangers present when gases are used in the conduct of anesthesia and when they are employed for therapeutic purposes. This discussion will omit entirely, however, any consideration of the hazards incurred from fires and explosions when compressed gases are in use. These hazards are believed to be too little understood at present to permit an authoritative consensus that might serve as a satisfactory guide for hospital management. For the present it is suggested that the member of the hospital staff who, according to the requirements of approved hospitals, is held responsible for the conduct of anesthesia in the hospital, also be made responsible for the elimination of danger from fire and explosion. On the other hand, dangers of another sort are present whenever compressed gases are used, and it is these dangers that we shall discuss.

Hazards in the use of compressed gases are not essentially different from the dangers constantly present in the administration of other toxic drugs. The training of doctors and nurses, however, has emphasized a knowledge of potent drugs that exist in the physical form of liquids and solids. The professional staff of the hospital is usually well trained in the use of the balance and the graduate for the control of dosage. Familiarity with the physical properties of gaseous agents is less common and there is often lacking a proper conception of the control of the dosage of substances administered by inhalation. The fact that the administration of gaseous agents by inhalation for therapeutic purposes is under second to second control should on first thought result in less frequent errors of a serious nature in the choice of drug and dosage. On the other hand, the extreme potency of the few gases in therapeutic use and their rapidity of effect when inhaled make it possible for them to be the cause of many hospital tragedies, unless the professional personnel can be brought to an appreciation of their physical and therapeutic properties and the proper means for their control. Two examples of the result of lack of such knowledge on the part of doctors and nurses may serve to emphasize the point.

A newborn child did not breath spontaneously. The doctor asked for "a carbon dioxide-oxygen mixture." The attendant nurse did not find a cylinder of carbon dioxide-oxygen mixture in the

usual place and ran into the corridor to look for one. She found there a cylinder of pure carbon dioxide, designed for quite another purpose, but noting the carbon dioxide label, she brought the cylinder to the doctor who inflated the lungs of the newborn child, with a fatal result. The doctor was in error as well as the nurse because he carelessly asked for "a carbon dioxide-oxygen mixture." Such mixtures are marketed in proportions varying from 3 per cent carbon dioxide and 97 per cent oxygen to 30 per cent carbon dioxide and 70 per cent oxygen, and one of the mixtures of a higher percentage might also have been fatal. Had the doctor been using a potent solid or liquid drug he would doubtless have checked the label by reading it himself, but because of his lack of familiarity with the gaseous preparation, he did not use ordinary care. A mere whiff of the gas into his own nostrils would have revealed the error.

A Fatal Error

In another case a gas-oxygen anesthesia was begun with an apparatus carrying one control valve for oxygen delivery but with two yokes, so that a reserve tank of oxygen might be always available. The previous day, a tank of pure carbon dioxide had been placed in one of these oxygen yokes and had not been removed. Since the tops of the two tanks looked exactly alike, they were both supposed by the anesthetist to contain oxygen. Being familiar with the properties of compressed gases, he realized that by opening the cylinder valves wide while the control valve was closed he could cause a flow of oxygen from the full tank of oxygen to the one partially full. Such a procedure would result in an equal division of the total supply of oxygen in the apparatus. Then by closing one cylinder and using the other, he would have early warning of need for a fresh supply. The maneuver was therefore performed.

Since the unrecognized cylinder of carbon dioxide was nearly full and under high pressure whereas the supply of the oxygen cylinder was nearly exhausted, the resulting mixture in both tanks was one of high carbon dioxide content. After one cylinder valve was closed, the oxygen control valve and the nitrous oxide were turned on and anesthesia was induced. The extreme hyperpnea which developed was treated with more "oxygen." Sufficient concentration of carbon dioxide to produce respiratory depression was then reached, and no further clinical evidence of physiologic carbon dioxide effect was manifest. After the undertaker's visit, the pure carbon dioxide cylinder was discovered on a yoke designed to carry a reserve oxygen cylinder.

Mistakes similar to these and others are occurring regularly in our hospitals. Examples could be cited indefinitely of mistakes in identity and unintentional mixing of all the compressed gases in common use. Such errors are exactly comparable to the administration of morphine sulphate when atropine sulphate is intended, or to the administration of morphine sulphate, grams 0.650, when grams 0.065 is intended. The factor of human fallibility or temporary mental lapses in the professional staff of the hospital will probably continue to cause accidents and fatalities from the use of gaseous drugs. Until the training of nurses and physicians includes a complete familiarity with the physical and pharmacologic qualities of compressed gases, accidents are more apt to occur with the less familiar agents. How can the hospital help to safeguard its staff from such tragedies?

The causes of accidents with compressed gases may be divided into five general classes: (1) carelessness in manufacture and in testing at the factory; (2) inconspicuous or confusing labels and painting of cylinders; (3) mechanical connections that permit unappreciated flow from sources of higher pressure to points of lower pressure, resulting later in the use of unidentified and dangerous mixtures; (4) hurried assembly of cylinders and apparatus in emergency cases and their use in dark rooms; (5) ignorance or heedlessness on the part of the hospital personnel allowed to handle and administer compressed gases.

Difficulties of the first class have been almost completely overcome by the manufacturers themselves. Toxic impurities are now almost unheard of in therapeutic gases manufactured by reputable firms. Some factories claim to make tests of each cylinder before shipment. Nevertheless, the frequent examination of samples of therapeutic gases taken from jobbers and hospital supplies is highly desirable. The Government now renders such a service covering liquid anesthetic agents. Such service should cover compressed gases used medicinally.

Labeling and Painting the Cylinders

The lack of uniformity in labeling and painting the cylinders is still a possible source of error in identifying compressed gases. There are still present in some hospitals in North America cylinders of oxygen painted red, while in others only ethylene cylinders are painted red. It is to be hoped that mixed supplies from the two sources do not come together in one hospital. Some manufacturers, in the interest of neat appearance, have painted all their medicinal gas cylinders a uniform neutral color with only a small portion colored to signify the identity of the contents. Labels likewise are in many cases uniform for different gases, the

identity of the contents of cylinders being indicated on the label only by writing in the name on a blank space on the label. This is particularly true of oxygen and carbon dioxide mixtures. Carbon dioxide is an extremely potent drug, capable of causing death in some patients by a few inhalations. It is probable that more care shown by the manufacturers in providing uniform and conspicuous labeling might help to prevent accidents.

A Dangerous Type of Apparatus

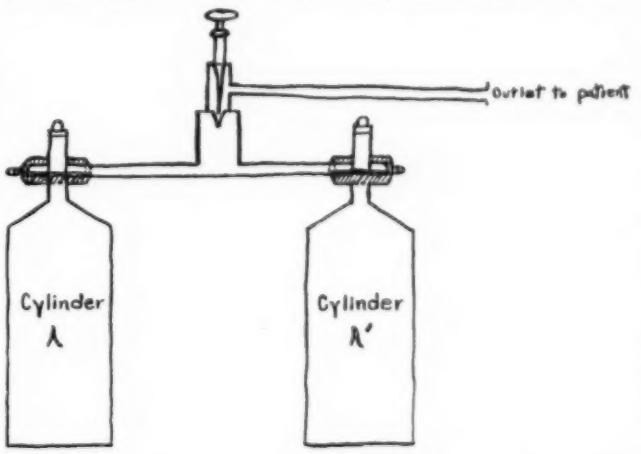
Mechanical connections that permit flow from sources of higher pressure to points of lower pressure, resulting in the use of unidentified and dangerous mixtures, often are not considered dangerous. If a bottle of tincture of digitalis and a bottle of laudanum stand side by side on the drug room shelf, they are safe from mixing even if the stopper of each bottle is removed. With gases under pressure, however, the conditions are entirely different. The accompanying diagram is a rough representation of a compressed gas control valve with two yokes, one conducting from compressed gas cylinder A and one from cylinder A′. Such an arrangement is designed by the apparatus manufacturer to permit a reserve cylinder A′ of a given gas to be always connected and available when cylinder A is exhausted.

When only two gases were used in medicine, nitrous oxide and oxygen, apparatus manufacturers provided one delivery control for each gas and there was no likelihood of a doctor or a nurse wishing to attach gases of different identity in the positions of A and A′. As more gases have come into use the temptation to continue the use of the old apparatus, which connects a cylinder in the yoke provided for A′ (a reserve stock identical with A), has persisted and a gas of a new identity B often has been placed in the position of A′. With cylinders of compressed gases A and B so connected, a mere failure to close tightly the cylinder valves (comparable to the cork being loose in adjacent bottles of laudanum and tincture of digitalis) will permit a flow of gas B into cylinder A, or vice versa, depending on which gas is under the greater pressure. If cylinder B is full and cylinder A nearly empty, the result of opening both cylinders will be that cylinder A will then contain a high percentage of gas B. This is what happened in the incident cited earlier in the article when oxygen was gas A and carbon dioxide was gas B. Carbon dioxide was then given to the patient under the mistaken impression of the anesthetist that it was oxygen.

Manufacturers of compressed gas apparatus have kept abreast of developments in the use of newer gases. They have also sent out warnings to hospitals concerning the dangers in using apparatus of old design. Unfortunately, not all hospitals have seen fit to modify or to replace their old equipment.

The hurried assembly of cylinders and apparatus in emergency cases and under conditions of poor lighting may bring about undesirable results. During the excitement of caring for an emergency case, either for operation or during attempts at resuscitation, cylinders are connected to the apparatus in the wrong position. Inexperienced orderlies, nurses, anesthetists and other members of the staff contribute to such accidents. Hurry and excitement are frequent causes of mistakes. Poor lighting facilities, such as are present in the fluoroscopic room and the room for work in the head specialties, may contribute to accidents.

The mental capacity and attitude of the hospital personnel permitted to handle and administer compressed gases is worthy of serious consideration.



In this gas control valve with two yokes, though it is designed to permit a reserve supply, the temptation is great to place gas of a new identity in A′. Then a mere failure to close the valves tightly will permit a flow of the new gas into A or vice versa, depending on which gas is under the greater pressure, and the patient may receive the wrong gas.

The cylinders in which gases are compressed are of necessity very heavy. Pressures in full cylinders range upward to 2,000 pounds per square inch. A strong man is often needed to move these containers. On the other hand, the content of the cylinders is often capable of producing death much more rapidly than any of the drugs in liquid or powder form to be found on the pharmacy shelves. The old saying, "A strong back and a weak mind," is not always true, but certainly the person chosen from the hospital staff to supervise the administration of compressed gases should not be singled out for this duty solely because he can lift the tanks. Some persons of a high degree of intelligence have a defective conception of the elementary principles of physics, and high pressure and low pressure of gases are alike to them. A valve means nothing to them because they cannot see the sub-

stance the valve prevents from flowing. Both professional and lay attendants of such a mental make-up are responsible for many accidents with compressed gases.

There is a growing tendency on the part of both the medical profession and the hospital management to appreciate that anesthetic drugs are extremely toxic and that they demand careful handling and administration. The present recognition of the necessity for one member of the professional staff being held responsible for the anesthetic department is evidence of this tendency. Such a person will solve most of the problems in connection with the use of compressed gases.

Why Careful Inspection Is Necessary

There is a tendency, however, toward carelessness in the supervision of the use of carbon dioxide as a therapeutic agent. The fact that carbon dioxide is a normal constitutent of expired air has tended to mask an appreciation of the possible dangers connected with its use as a therapeutic agent. The opportunities for dangerous or fatal error in the use of carbon dioxide alone or in mixtures with oxygen are quite as great as with the use of other compressed gases. Although manufacturers have been extremely meticulous in the preparation and marketing of compressed gases for medicinal use, we believe an added check in the form of more careful inspection of such gases, including carbon dioxide, would be beneficial.

One of the bureaus of the Government has for some time made a practice of analyzing samples of ether from the open market. Whether an attempt has been made to check in a similar manner the supplies of compressed gases for medicinal use, we do not know. In any case we believe this could be done to advantage and that such an analysis might include inspection of carbon dioxide for medicinal use. Such an inspection could be made to serve as a check on the labeling and the painting of cylinders, which are so important as a prevention of mistakes in the identity of compressed gases.

In the commercial use of compressed gases, mistakes in identity have been avoided to some extent by the use of different thread connections for explosive gases so that it is impossible to connect an explosive gas cylinder to a nonexplosive gas inlet. A manufacturer of anesthetic and therapeutic gas apparatus makes the following suggestion for the prevention of mistakes in the identity of compressed gases. "Every manufacturer of compressed gases to be used for therapeutic purposes should be required to market his products in cylinders, the valves of which are individual for each gas. The apparatus manufacturer should likewise be required to supply individual yokes or threads. As a result, an attempt to attach a carbon dioxide cylinder to an oxygen inlet or an ethylene cylinder to a nitrous oxide inlet would be physically impossible." This suggestion, if carried out, would undoubtedly eliminate many of the dangers to which our patients are now exposed.

The organization of anesthetists has tried for several years to induce manufacturers to agree to a uniform labeling and painting of medicinal gas cylinders but without success. It is evident, therefore, that before any uniformity of effort can be expected, some Federal agency must be set up, with absolute authority to enforce uniform regulations.

In the meantime, hospitals can best safeguard their patients from the dangers here discussed by making sure that the administration of compressed gases is placed in the hands of intelligent persons. Orderlies entrusted with handling cylinders and apparatus should be chosen for their intelligence and reliability and not for their strength. At least one physician of the professional staff should be held responsible for the instruction and direction of nurses and orderlies who may be required to assemble, clean or otherwise come in contact with compressed gas equipment.

Actual administration of compressed gases, either for the alleviation of pain or for other therapeutic purposes, should be the direct responsibility of a physician just as is the administration of other toxic drugs. The fact that compressed gases require more elaborate apparatus for their control in administration only adds to the seriousness of the responsibility of the person charged with their use. It is unfair for a nurse or an orderly to be held responsible for the handling and administration of compressed gases when the physician devotes his individual attention to the administration of solid and liquid agents.

How the Chicago Clinics Staff Uses the Health Service

An average of almost one visit for every participant in the staff health plan was attained at the health service of the University of Chicago Clinics during February. The records show: medical examinations, 129; out-patient visits, 744; refers to other clinics, 69; x-rays, 26; hospital admissions, 59; house calls, 19.

The health service program at the university has been established only for a short time. The plan was described somewhat in detail in the January and February numbers of THE MODERN HOSPITAL.

How Indiana Cares for Its Young Convalescents

By EDWARD T. THOMPSON, M.D.
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THE Indiana Rotary Convalescent Home is the latest addition to the Indiana University Hospitals, Indianapolis, a group that is composed of the Robert W. Long General Hospital, the William H. Coleman Hospital for Women, the James Whitcomb Riley Hospital for Children, the school of medicine and the training school for nurses at the Ball residence.

The convalescent home for children, which was erected and equipped at a cost of $250,000, is a gift of the Rotary Clubs of Indiana. It was formally dedicated on November 15, 1931, and immediately put into service. The home stands in the center of a fifteen-acre plot at the northwest corner of the campus and is within 400 feet of the Riley Hospital. As the medical center occupies a campus of fifty-three acres adjacent to city park land of seventy-five acres, it was thought advantageous to place the home near the Riley Hospital.

The building is a three-story structure with accommodations for patients on the first and second floors, and for the personnel on the third floor. Attractiveness and a homelike atmosphere have been the keynote of construction. The skeleton form of the building is of reinforced concrete covered with red masonry walls with Indiana limestone trim.

The building faces the south. Most of the accommodations for the patients are also to the south, with the utility, lavatory and other service rooms to the north to ensure as much sunlight as possible for the children. Broad open and closed terraces to the south provide additional possibilities for heliotherapy. Arched entrances strike an artistic and dignified note. It has been the intention to keep as far away as possible from institutional construction and equipment. The main entrance, the pleasant lobby and the reception room with a compactly designed and not too noticeable office are excellent examples of this thought.

At mealtime, happy informal groups gather at the tables which are suited to the size of the child.

Two floors are designed to accommodate sixty-six patients. The third and top floor can comfortably house about thirty members of the personnel. On the first floor are two eight-bed wards, two six-bed wards and two single rooms that may be used for isolation purposes. Each ward room is well lighted, well ventilated and made cheerful by the use of beds finished in a pleasing green color. There is a small cedar chest at the foot of each bed. These chests are novel in that they serve as chairs and as utility chests for the storage of the children's clothing and of their personal belongings and toys. Each ward has two built-in lockers for each child where the outdoor clothing, towels, wash cloths and soap may be kept.

Two sun parlors are on each floor and are placed adjacent to wards so that they are easily accessible to the children. These sun parlors are equipped with a special type of furniture designed to resist exacting wear and at the same time to follow accepted standards of sun parlor furniture. Casement windows and Venetian blinds are used. The floors are of light brown rubber, with animal inserts which delight the youthful patients. The colors of the floors and furniture blend with the tan glazed brick that has been used in the construction of the walls. Each sun parlor has also a phonograph and a radio.

Provisions have been made for the educational needs of the children. A kindergarten and a schoolroom are on the first floor and there is a schoolroom on the second floor. These rooms are supplied with all the specialties needed for teaching as well as with especially designed chairs with attachments that aid the crippled children.

The dining room is on the first floor and has tables of two sizes, each table seating from six to eight children. These tables are of maple with a natural finish and are not only attractive but are practical in that they are easily kept clean. The floor of the dining room is of rubber laid in a black and green checker design. A serving room adjoins the dining room, the food being prepared in the kitchens of the Riley Hospital and sent to the convalescent home in electrically heated trucks through the connecting tunnel.

It is the plan of those in charge of the convalescent home to afford a place where the child may convalesce and at the same time to teach him to care for himself in as many ways as possible. The arrangement of the dining room and the plan of having as many patients as possible sit at tables instead of using trays affords an opportunity to teach the child what to eat and how to eat.

Two washrooms on each floor have been planned with the needs of the convalescent child in mind. These rooms at each end of the hall are accessible by means of large openings not hung with doors. This permits a child in a cripple cart or wheel chair to reach the washrooms easily and to care for himself with the least amount of difficulty. The washbasins have been placed at different heights to accommodate children of various ages. Toilet rooms, baths and shower rooms adjoin the washrooms.

In the center of the corridor on each floor there

Playing in the sunshine on the open upstairs terrace is a pleasant part of the heliotherapy provided for the children. In the lower picture can be seen the terraces of the home and the three arched entrances which strike an artistic and dignified note.

is a built-in nurses' station with a utility room on the second floor and a treatment room on the first.

The second floor is a duplicate of the first with the exception of a library and a six-bed nursery that have been provided. An open terrace with a high protective iron grille has been built over the terrace on the ground floor. A large room now being used as a general assembly room occupies the space over the dining room. Corridors and stairs throughout the building are covered with a rubber flooring in a light green color. This color blends admirably with the corridor walls which have a dado of light green glazed tile.

Beautiful Playground Is Planned

It is the plan in the near future to develop a playground which will occupy a space immediately in front of the building. A description, which appeared in the dedication program, of this playground is as follows: "The broad verandas of the building will overlook this park and playground. Falling gently away from the building entrances it will contain tree lined walks, suitable for wheel carts, roller skates and toy wagons. Nearer to the building will be the play spots for infants, with sand boxes, baby swings and playground apparatus. In the middle distance will be found the teeter totters, the larger swings, the doll houses and the Maypoles for older children. Still farther away, in roomier spaces, will be placed the ball diamonds, the horizontal bars, the gymnasium horses and other apparatus which goes to make up the play life of the bigger children.

"Surrounding the entire playground will be a

brick wall, of sufficient height to ensure privacy. Here and there throughout the grounds will be clumps of trees and shrubs for beauty and shade. Statuary and instructive pieces eventually will be placed at interesting points along the walks. This playground promises to become one of the show places of Indiana. It will be the gay garden spot of the Riley Hospital plan; a happy park for play."

Those in charge of the Rotary Convalescent Home have recognized the fact that during illness the child has become accustomed to a routine that is seldom duplicated in the home for the reason that parents do not possess the means, facilities or technical knowledge necessary to carry out such a routine, and that some place should be provided where the child can pass a transition period and eliminate some of the difficulties that confront any patient when he leaves the hospital and returns home. The fact that this period of transition affords an excellent opportunity to give the child any training he may need has not been overlooked, and for this reason the schoolrooms, the kindergarten, the library and play facilities were included in the planning of this building.

The Rotary Convalescent Home will stress the fundamentals of child life—rest, work, play and education. Such professional care as is needed for the patient will be continued by the staff of the Riley Hospital. The proximity of the home to the Riley Hospital makes the availability of further medical care for the patient during his convalescence one of the most important of the advantages of the convalescent home.

Should the Dispensary Conduct a Mental Hygiene Clinic?

One of the newest and most encouraging developments in the practice of community medicine has been the organization of public mental hygiene clinics. That the psychiatrist and psychologist can do much to assist in untangling family difficulties and thus keeping intact the family circle must be granted.

Most of the patients to whom mental hygiene clinics can render the greatest service do not suffer with organic mental or nervous disease. They usually present signs of family or social maladjustment which require for correction the most careful and painstaking study. The conduct of such a clinic, therefore, is not work for the tyro. The personnel of a successful mental hygiene clinic must consist of trained men and women with salaries proportionate to their abilities.

The average hospital, however, cannot afford to engage full-time well trained psychiatrists, psychologists and social workers and hence the hospital mental hygiene clinic is often inadequate. There is no reason why a hospital should not endeavor to perform this type of work, but there is a great question as to whether it should endeavor to do so if it is unable to perform this service efficiently. It would probably be a better plan to attach such a clinic to the department for the prevention of disease. Nevertheless, if no other community facilities are available, an incomplete effort is far better than none at all.

Mental hygiene clinics are capable of meeting a real need in the community and whether they are under governmental or private control, their cost is certainly justified in consideration of the service they render.

Securing Prompt Accident Service for the Small Hospital

In a small hospital with an intern staff of less than half a dozen, it is usually impossible, as well as unnecessary, for an intern and nurse to remain continually in the accident ward. Because of this fact there is often delay when a patient suffering from a major or minor trauma is brought to the institution.

It is a common experience for patients suffering with more or less minor injuries to be required to wait for periods ranging from a few minutes to an hour or more for the appearance of the house doctor. Frequently it is expected that the patient will notify some one in authority of his presence by telephoning or by pushing a button which rings a bell in the office of the superintendent or the directress of nurses. Often the victim of an accident is in such a perturbed state of mind that he is unable to appreciate the necessity for some action on his part and simply impatiently awaits the arrival of a physician or nurse to attend to his wants.

Foreigners coming to the hospital should not be expected to telephone, especially when a dial system exists. Often the presence of a push button near the entrance of this department is of less avail. If a trained attendant could always be on duty in the accident ward, devoting his spare time perhaps to the making of dressings, plaster of paris bandages or to some other useful employment, this problem would be largely solved.

At any rate, an institution maintaining an accident ward should recognize the fact that the public has a right to prompt service and that some practical measures must be adopted whereby this type of service can be rendered.

How an Effective Admitting Plan Saves the Hospital Money

By B. W. STEWART
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THE title of this paper should be "Hospital Admitting and Discharging Procedure," since the two are so closely associated that they can hardly be separated.

The Cleveland Hospital Council's plan for admitting patients is so excellent that I have asked and received permission to incorporate a part of the plan in this paper. It is well worth considering. Although the part dealing with the collection of accounts through the Cleveland Hospital Council has been omitted, it is replete with helpful suggestions for those cities that have a central council.

In these days of financial stress, when hospital administrators are economizing in every possible way, they may be neglecting the very department that may be losing more than it gains by such economy.

Hospitals need to exercise control over the methods used in the giving of part-pay and free service, as well as those used in collecting for full-pay work.

It is desirable that hospitals establish a uniform principle covering the investigation and approval of part-pay and free cases, as well as uniform methods for the collection for service rendered to full-pay cases.

The admitting officer is an important person in any hospital organization. A study of this key position leads to the conclusion that if this position is not assigned to the proper person the admitting procedure is a failure. If the admitting officer does not assign the patients to accommodations within their means, the loss that is sustained by the hospital may nullify the efforts of a competent administration to save money for the institution. Also, if patients are assigned to accommodations for less than cost, when they are able to pay more, there is a loss.

The financial gain to the institution by proper admitting methods is by no means the all important one. The satisfaction of the patient and his ability to pay for the service to which he is assigned as well as the good will the hospital enjoys are of equal importance.

The same procedure is possible regardless of whether the admitting officer is a nurse, a night

YOUNGSTOWN HOSPITAL
North Side

Reg. No.....
Name..... Admitted..... 19.... A. P. M.
Address ..... Room No.....
Age..... Nationality..... Religion..... Color..... M. F. S. M. W.
Name and address of nearest relative or friend.....
..... Phone No.....
Occupation .....Employer .....
Charge to ..... Check No.....
Admitted by Dr.....Treated by Dr.....
Conveyance .....Admitting Officer.....
Information given by.....
Remarks .....
.....
Provisional diagnosis .....
Intern notified .....

supervisor, a clerk or a cashier. The small hospitals may not have an admitting clerk but, regardless of the person who does the admitting, they should follow the same procedure. Admissions made at night should be checked the following morning by those in charge of the credits during the day. The actions of the admitting clerk are powerful factors in building the good will that is one of the hospital's most valuable assets. It is strange but true that many persons upon entering the hospital want to give the impression they have money to pay their way and demand the best, and yet upon leaving the hospital they seek to give exactly the opposite impression. They are poor, they say, and cannot pay.

The admitting officer should have the following qualifications: a knowledge of hospital routine; a business training and a social point of view that will enable him to obtain and evaluate information regarding the ability of an individual to pay for hospital service; a personality that will enable him to deal with all classes of patients satisfactorily. The admitting officer should be responsible to the administrative officer.

The model admitting officer is preferably a woman, neither too old nor too young. She has a pleasing personality and dresses tastefully and neatly. The initial contact can influence the patient throughout his or her stay in the hospital. If it is unpleasant it will long be remembered by the patient even though he may be satisfied with the rest of the service.

When the patient has applied for service, the admitting officer tactfully obtains all the information necessary to the assignment of the patient to accommodations that his financial circumstances indicate he can pay for. If the patient requests private or semiprivate room service and if, in the light of the information the patient has given, the admitting officer feels that the patient is unable to pay for such service, he carefully explains to the patient that the service he will obtain in other accommodations will be equally satisfactory.

The Folly of Overselling

If the hospital has any extra charges or higher charges for service in private rooms than in the wards, this is also explained carefully to the patient. So often patients merely figure the fifty cents or a dollar, or whatever it may be, difference in the price of the room and are surprised that there are additional extras. It is always well to examine the account of any patient wishing to move from low priced to higher priced accommodations. This is especially true of accident cases.

The overselling of accommodations should not be tolerated in any institution, and this should be emphatically stated as part of the instructions to the admitting officer. Permitting patients to take private room accommodations is sometimes an injustice to them.

The overselling of accommodations has a bad effect on the friends of the patients and on the public. The more the hospital oversells accommodations, the harder it is to collect the account. The family and friends of the patients will often insist on better accommodations than they can afford. This can frequently be avoided if the patient is made to understand that the care he receives will be as satisfactory and his chances of recovery as good in the cheaper accommodations. All extra charges, for operating room, laboratory, anesthetic, x-ray and special medicines, should be explained to the patient. Especially should he be told if these charges are higher in a private room than in the ward. The public must be educated to realize that hospitals expect their service to be paid for.

Recording Patient Days

In the recording of patient days, the following outline should prove helpful:

1. A pay day is one day of service rendered to any patient who is billed as much as the established ward bed rate.

2. An allowance day is one day of service rendered to any patient who by reason of his economic status is billed less than the established ward bed rate.

3. A free day is one day of service to any patient to whom by reason of his economic status no bill is rendered. A complimentary day is one day of service rendered to any patient who, because of his hospital affiliation or because of reasons other than economic, is not billed for service. This does not include service rendered to employees. An employee day is one day of service rendered to an employee of the hospital for whom no bill is rendered. (An industrial day's service shall be recorded as a pay day.)

The hospital should maintain an admission register, this register to provide for the recording of admissions according to the classifications mentioned and also to provide for the recording of the total days of service rendered to each patient according to these classifications. At the time of admission, all private cases are recorded as pay patients. After a detailed financial investigation, all cases admitted as free patients are listed as free patients. All complimentary days and employee days are properly recorded at the time of discharge. The total number of days of service are recorded according to the respective status of the patients.

It is the duty of the admitting officer, preferably before the patient arrives at the hospital, to obtain a credit rating from the Retail Credit Association in order to be able to assign accommodations properly. Exception to this is made in the case of patients paying in advance and who continue to do so.

The ratings shown in the Retail Credit Association records at the present time are not of much value, because the changes have been rapid in the past year. The hospital can frequently establish credits through a close contact with the members of its medical staff, since they are quite often in a position to reveal the truth about the financial affairs of the patient. At the same time the hospital must guard against certain members of the medical profession who will want to get the best for all their patients regardless of their ability to pay. In the average hospital a great number of patients come in through the emergency department or in an invalid carriage; then it is a case of the hospital's making arrangements with the nearest relative or friend. An alert admitting officer can often tell from the street address whether or not the patient is able to pay.

There should be an absolute understanding about the financial arrangements before the patient is admitted. Each hospital will have its own arrangements, but the important thing is to have them made before the patient is admitted.

The practice of having the patient pay in advance or sign a guarantee of payment should be continued in those hospitals in which this procedure is now followed, and those hospitals that are not now requiring a signed guarantee of account should do so for the protection of their own interests.

Guarantees of Payment

In securing signatures on a guarantee of account, the admitting officer should be instructed to obtain the address of each person signing in order to obviate any difficulty in locating or tracing the person who has signed a guarantee.

There are two kinds of guarantees: (1) when the account of the patient is to be charged to another person; (2) when a guarantor assures the payment of the bill for services rendered to the patient. In the first case, it is well for the hospital to have an order which reads, "Please render services to ..... and charge the same to my account." On an order of this kind, it is necessary to establish the credit of the person giving the order as the hospital releases the patient from all responsibility. The second guarantee is preferable since the other person guarantees the payment of the bill for services rendered to ..... In this case, the hospital can hold the patient as well as the guarantor. If the account is to be charged to an industrial company, a communication should be sent to the company asking it to guarantee the bill, or if it carries industrial commission, to give the hospital the claim number. If it should be a township, city or county case, it is well for the hospital to get the permit or authorization signed as quickly as possible so that in cases where the patient is to be responsible, the bill can be collected before he leaves the hospital.

How Accounts Should Be Classified

A charge should be originated for every patient admitted to the hospital regardless of the source from which patients have been referred. With two exceptions, a bill for service should be rendered to every patient. These exceptions are: (1) cases referred by social agencies when a previous financial investigation has been made, the findings of which in the opinion of the admitting officer warrant free service; (2) cases referred by the hospital dispensary after a detailed investigation has been made by the social service department, the findings of which in the opinion of the admitting officer warrant free service. Accounts of these two groups should be charged to "free service."

When patients are admitted accounts should be definitely classified as pay, part-pay or free. If they are pay, they should be marked as to what collection method the hospital wants to use in case the bills are not paid—whether the hospital wishes to threaten suit, or whether the patients should be sued in case of nonpayment. A hospital has a right to sue, and some cases should be sued. On the other hand, if it is found that the patient has a large family and is the wage earner of the family, or if it is discovered that he has been out of work and that there is no chance to collect, it is better to charge the account to charity when the patient is dismissed, rather than to build up a large amount of accounts receivable and thereby have a large amount to charge off as uncollectible. (This does not mean that the hospital cannot send statements or letters to certain cases only, even though the executive feels that the account probably cannot be collected.)

It is only by the proper classification of accounts that hospitals can obtain the proper credit for part-pay and free work. Most hospitals do a large amount of charity work by way of unpaid bills for which they get no credit. In the average hospital doing a large amount of work in accident cases and out-patient departments, the number of bills returned because of wrong addresses is amazing.

Many of these could be eliminated by better supervision in admitting patients.

The entire procedure of admitting and discharging may be summarized briefly as follows:

The hospital obtains the information necessary for the admission of the patient. Someone, preferably the person in charge of admissions, takes the patient courteously to the floor or room, and turns him over to the nurse in charge. The cover for the history or chart is made, giving available information. This is given to the nurse. A copy of the admission is given to the office for the account. The intern on service is notified. If the hospital does not have interns, the attending physician is notified that his patient has arrived at the hospital. All patients' discharge orders are signed by the attending physician. The office is notified when the patient is ready to be discharged. A card is sent to the office and if the account has been settled according to arrangements, an O. K. is put on the card; if not, either the patient or a friend of his is requested to come to the office. The nurse takes the patient to the door, and if necessary helps put him in the car.

This paper has dealt with the procedure for patients who come in the regular way through the admitting office. If the patient is an emergency case, treatment is given first; the regular procedure may then be followed either at the patient's bedside if the patient is able to talk or, if not, with his friends or relatives. If a patient comes in without being sent by a physician, except of course an emergency case, he should always be examined by an intern, the chief resident or a staff physician before he is admitted. A patient who is very sick should never be kept waiting. He should be taken to the room or bed immediately. Information may be obtained later from relatives or friends.[1]

Submedical Groups Are Made Subject of Study

Releasing authentic figures revealing there are in the United States today approximately 47,000 midwives earning $3,000,000 annually, 4,925 chiropodists earning $14,775,000 and 20,206 optometrists, Dr. Louis S. Reed in a report just submitted to the Committee on the Costs of Medical Care recommended "organized cooperation" between these "secondary practitioners" and doctors of medicine, and urged higher standards for them.

Doctor Reed's eighteen months' study, which has just been published by the University of Chicago Press under the title, "Midwives, Chiropodists and Optometrists—Their Place in Medical Care," is the fifteenth in the series of studies being made by the Committee on the Costs of Medical Care under the chairmanship of Dr. Ray Lyman Wilbur.

The committee will in the autumn of 1932 issue its final report which will include recommendations based on its exhaustive five-year study into the problem of "the delivery of adequate, scientific medical service to all the people, rich and poor, at a cost which can be reasonably met by them."

Compared with the 142,000 active doctors of medicine, the 67,000 dentists and the 200,000 trained nurses in the United States; the 72,131 midwives, chiropodists and optometrists constitute an important percentage in the total number engaged in providing medical care in the country.

The total number of such secondary practitioners and the amount spent annually for their services, according to Doctor Reed, are: midwives, 47,000, $3,000,000; chiropodists, 4,925, $14,775,000; optometrists, 20,206, $50,000,000, including the cost of glasses they furnish; total, 72,131, $67,775,000.

When Is a Hospital Liable for a Surgeon's Negligence?

Is a hospital liable for a surgeon's negligence especially if the surgeon is a member of the staff and an officer and stockholder of the corporation that owns the hospital?

The supreme court of South Carolina said "no" to this question in a recent suit brought against a private hospital because the operating surgeon had left a piece of gauze in the wound of a woman patient on whom he had performed an appendectomy. The case is reported in the *Journal of the American Medical Association.*

The surgeon was chosen and employed by the husband of the patient, at the suggestion of her physician and not at the suggestion of the hospital. The fact that the surgeon was financially interested in the hospital had nothing to do with his employment.

The court held that the owner of a hospital, when it is conducted for gain and not for charitable purposes, is liable for only such damages as accrue from the injuries caused by the owner's own negligence or by the negligence of his agents, servants or employees, each with the scope of his own employment.

If the surgeon employed by a patient or on his behalf is not an employee of the owner of the hospital, the owner is not liable for the negligence of that surgeon. Such was true in this case.

[1] Read at the meeting of the Ohio Hospital Association, Akron, March 15-16.

A County Hospital That Will Serve Also as a Health Center

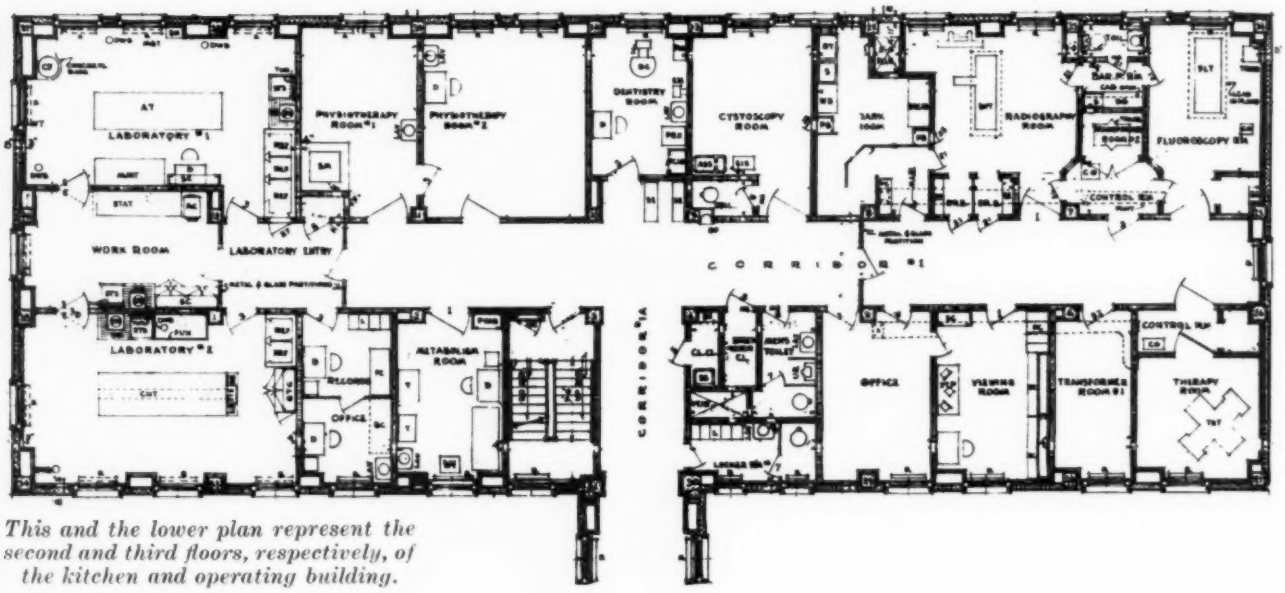
By Office of JOHN RUSSELL POPE and WILLIAM F. McCULLOCH
Associate Architects, and
S. S. GOLDWATER, M.D.
Consultant, New York City

THE Meadowbrook Hospital, which is to be erected by the County of Nassau, Long Island, N. Y., on a sixty-acre site near Hempstead, will stand in a pleasant countryside and occupy a central position with respect to the county it is to serve.

Since the institution is designed for development as a public general hospital of 600 beds, a group arrangement has been adopted with a view to convenient expansion by means of lateral extensions of the provisional structures. On the accompanying group plan it will be seen that the buildings are placed in two categories—those scheduled for immediate construction and those to be erected in the future. The first construction will include the central ward or patients' building, a composite central service building, a unit for contagious cases, a nurses' home, a structure housing help's quarters, laundry and garage, and the power house; together these buildings will provide all the elements required for the smooth working of a hospital of 200 beds.

Both the first and the later Meadowbrook buildings will be grouped in roughly symmetrical manner about a general north-south axis, while the main entrance court, when formed by the first section of the nurses' home and the subsequent administration building and west patients' building, will be centered upon a secondary axis running east and west. An abundance of elbow room has permitted the use of buildings averaging three stories in height, but the ultimate spread of the completed plan will be no greater than is consistent with efficient centralized administration. The first ward patients' building and the supporting central service unit are separated by a light court 70 feet in width, but since they are connected by a corridor at every floor they will function virtually as one. Other parts of the hospital do not require so close a connection as this, but they are nevertheless to be interconnected by underground passages.

Exteriorly the principal Meadowbrook buildings have been designed in the spirit of the Greek Revival. Construction will be of reinforced concrete, with brick walls finished in two tones of stucco and cast stone trimmings. While the

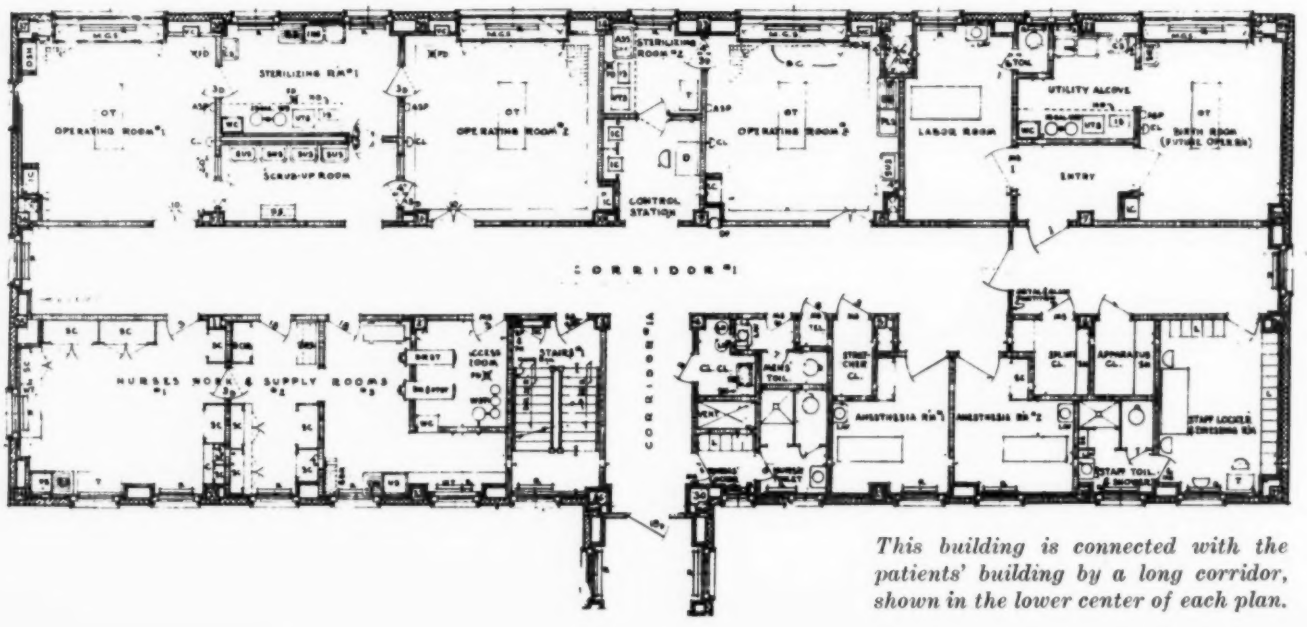


This and the lower plan represent the second and third floors, respectively, of the kitchen and operating building.

hospital is planned to function properly upon the completion of the first six buildings, it is designed architecturally with a view to the future. As a result, the planners have made a studied effort to prevent unwarranted expenditure in the embellishment of those buildings which will "bring up the rear" in the completed group.

The orientation of the group provides a broadside southern exposure for all patients' buildings, and the full value of this exposure has been utilized by the assignment of the entire south side of each floor to patients and the concentration of elevators, stairs and utilities on the north side. Of sixty beds on each typical ward floor, fifty-four are placed in nine six-bed wards which face south. Of the patients' rooms only the separation rooms, four in number with space for six beds in all, are on the north side of the building. All wards have a large part of their exterior walls of glass, and open on to cantilevered balconies 5½ feet wide. In the winter season when the sun is low such balconies will not interfere with the entrance of sunlight into the wards, and during the high sun of summer they will serve as an awning. At either end of the central or first patients' building is a large solarium projecting in the form of a semicircle of continuous glass.

The six beds in each typical ward are symmetrically disposed in two three-bed rows, with a short aisle of comfortable width between the rows. Each ward has a washbasin of the clinical type with lever controls, and standard electric equipment which includes semi-indirect illumination of two intensities, convenience receptacles at the bedside, night lights placed below the level of the beds, nurses' call system, fan outlets, power outlet for portable



This building is connected with the patients' building by a long corridor, shown in the lower center of each plan.

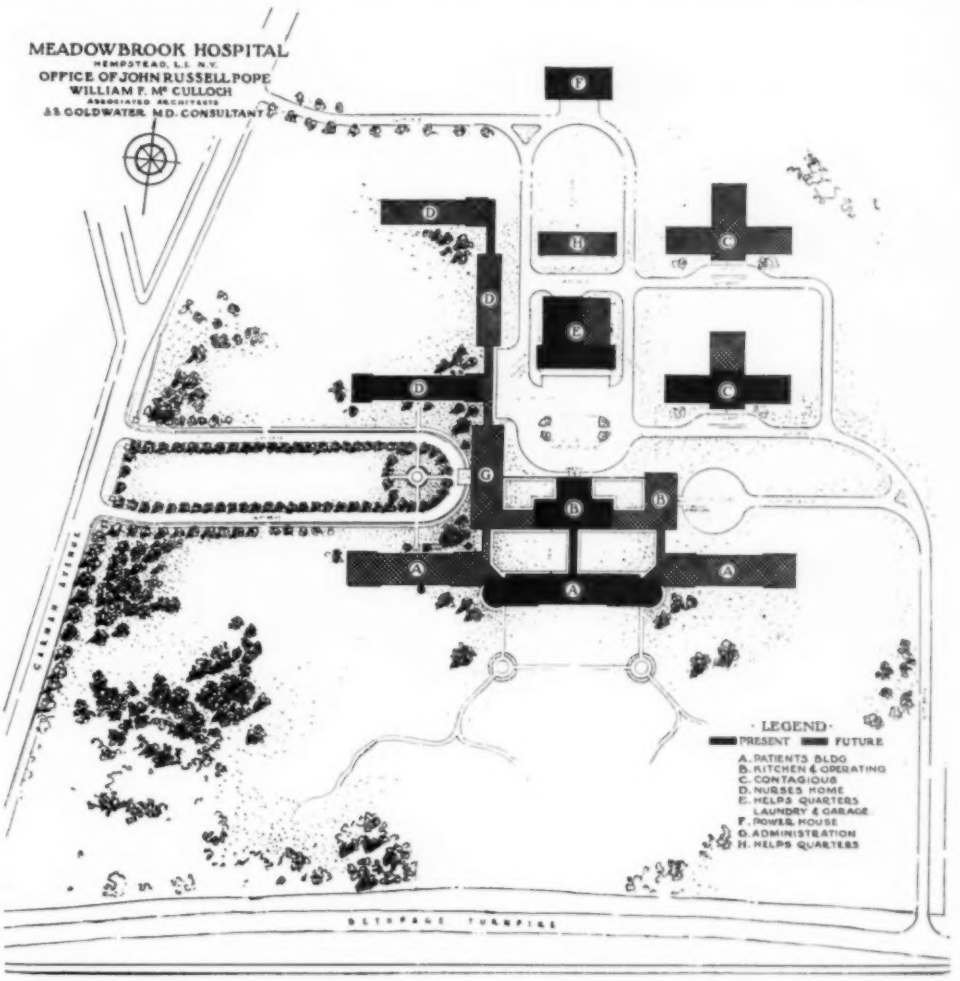
x-ray equipment, and radio connection. The intention is to provide an adjustable hanging curtain for each bed. In cubical contents the wards exceed slightly the legal requirement in New York State of 800 cubic feet per bed.

In summer the wide open doors and windows on the southerly side of the almost square ward, and the double door with hinged transom which connects the ward with the adjoining cross-ventilated corridor, will help the prevailing southerly breezes to flush the ward freely. In winter ventilation can be maintained by means of a hinged transom centrally placed over the double balcony door and by a hinged upper and lower section, opening inward, with which each side window is equipped. Ventilation in winter will be aided by mechanical exhaust.

The ward plan, somewhat unusual for a general hospital, was motivated by a desire to take full advantage of the wide southerly extent of the site, in a section of Long Island where sun and breeze are invigorating, and also by the necessity of developing a plan for a general county hospital in which a great variety of acute and chronic diseases are to be treated and where larger open wards would have prevented a proper classification of cases. No attempt will be made here to describe the ward equipment in detail; it must suffice to say that due regard was paid to the control of disturbing noises at their sources, and that the location, equipment, finish and decoration of the various service rooms have been controlled by considerations of function.

The children's department to which a set-back fourth floor has been assigned, reproduces the principles of the typical floor, with somewhat smaller wards in which fixed cubicle partitions in place of hanging curtains separate the individual beds, and with a larger proportion of separation rooms. The children's ward has its own solariums and roof spaces. Owing to its location, the children's ward can be quarantined without disturbing the adult ward service.

Until the erection of the administration building and the second patients' building to the west of the first central structures, the out-patient clinic, the administrative offices and the interns' quarters of Meadowbrook Hospital will be on the first floor of the central patients' building. The temporary public entrance is here, and the two solarium spaces on this floor will be used for the present as an out-patients' waiting room and a con-



Both the present and future buildings will be grouped in a roughly symmetrical manner about a general north-south axis, while the main entrance court, when formed by the first section of the nurses' home and the future administration building and the west patients' building, will center upon a secondary axis running east and west.

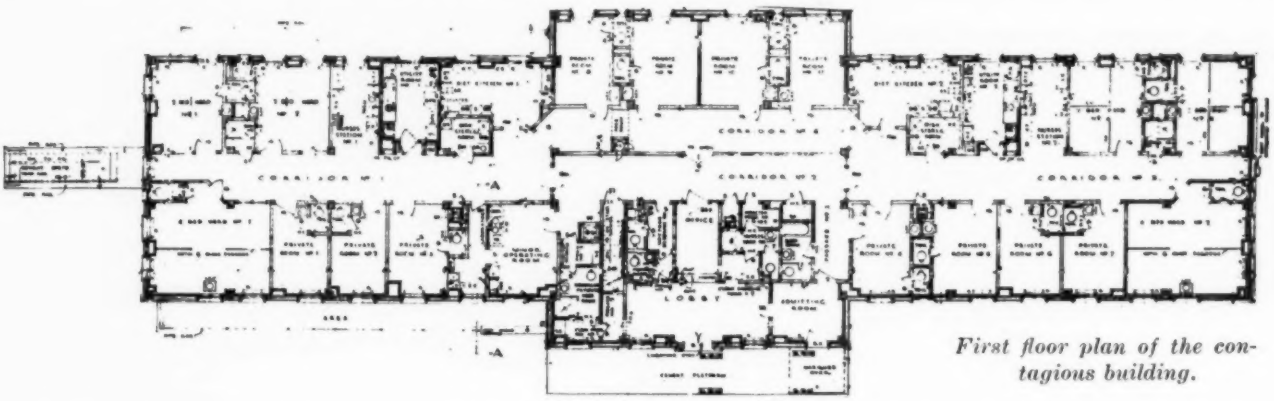
ference room, respectively. Subsequently, this floor will be recaptured for the exclusive use of patients, presumably of convalescents or chronics or both, who by means of ramps will have direct access to the spacious park, more than 400 feet wide and at least three times as long, that separates the patients' buildings from the parallel boulevard to the south.

Certain features of the service building as well as of other members of the group which must be grasped in order to understand the general plan will be summarized as briefly as possible:

Kitchen: At ground floor level; central location; level corridor connections with all dining rooms and with contagious building; adjoins goods receiving station and central storeroom; cold storage and central preparation room between goods entrance and kitchen proper; separate diet kitchen; ample windows; mechanical exhaust ventilation; pastry kitchen and scullery adjoining; space and connections for heated food carts; planned for future expansion without costly rearrangement of original fixtures.

Service Entrance: Level entrance from service court (wards face away from not towards service entrance); commodious lobby, general supply room adjoining, bulk storerooms next; direct connection with kitchen stores which in turn adjoin food preparation room; conveniently related to morgue, which, however, is entered through a separate rear passage.

Emergency Department: Ambulance entrance at ground floor level; not visible from wards; plenty of elbow room for ambulances; two emergency rooms, one of extra size; separate receiving wards for men, women and children; isolation and detention rooms for psychopathic cases, opening off two private interior corridors which join central nurses' control station; receiving baths; ready access to patients' elevators; not far removed from the x-ray department and the operating rooms.



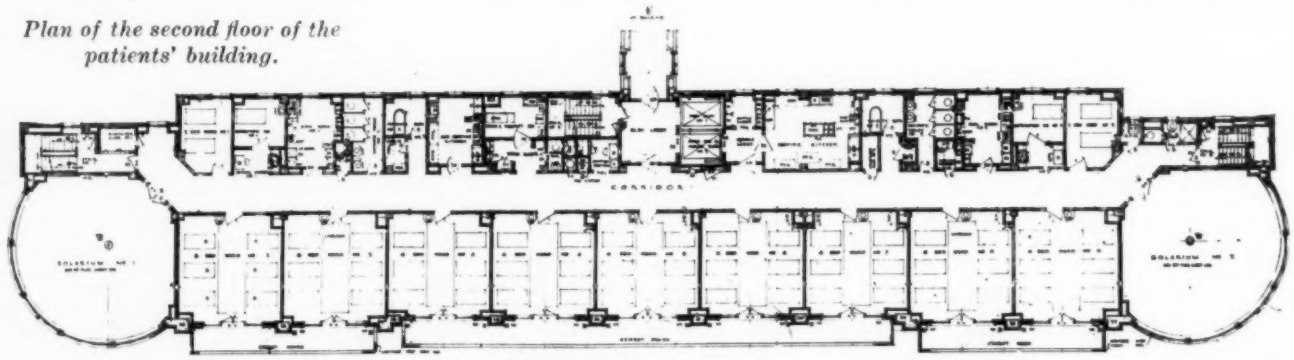
First floor plan of the contagious building.

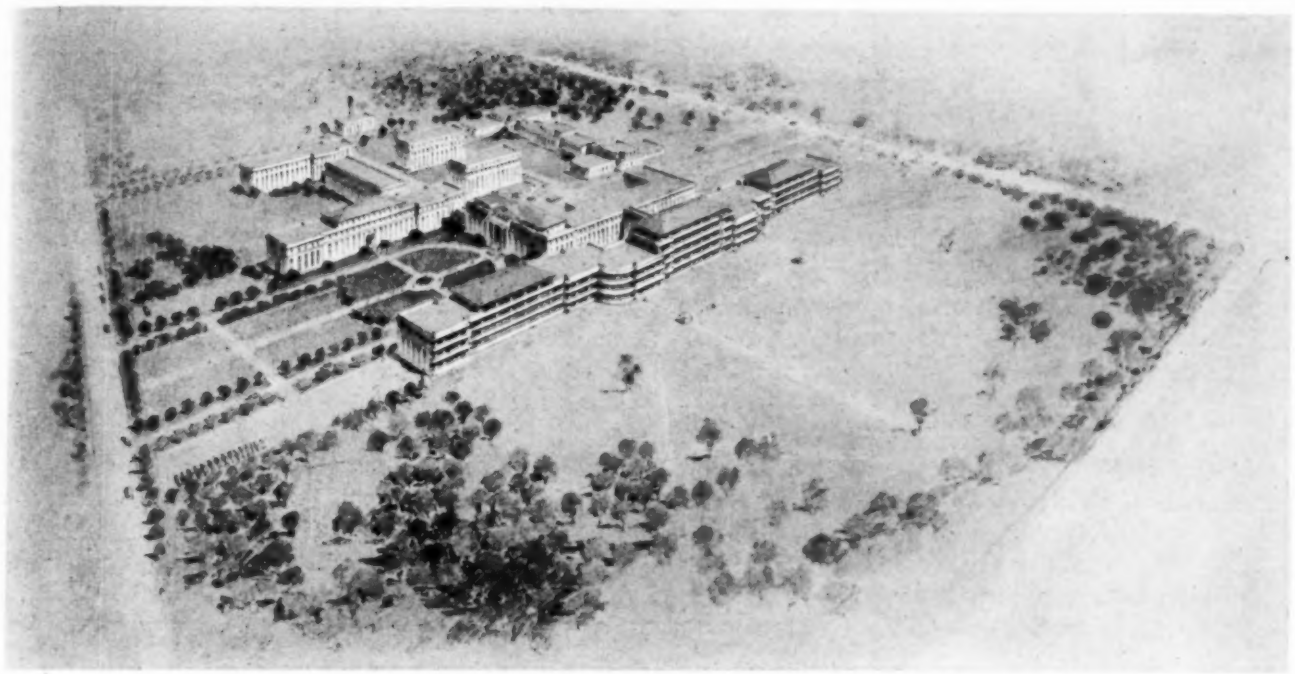
X-Ray Department (second floor of service building): Ample light and ventilation; constructed with usual safeguards; level connection to middle ward floor of three-story ward building; lies directly above emergency ward and just below operating rooms; separate rooms for radiography, fluoroscopy, radiotherapy, urology, dental x-ray work.

Clinical and Pathological Laboratories, Basal Metabolism, Physiotherapy: Central location; accessible from wards and O. P. D.; near operating rooms; share with x-ray department second story of a building which has a wider spread on the first floor and of which the second floor can be extended at minimum expense, when and as more space is required.

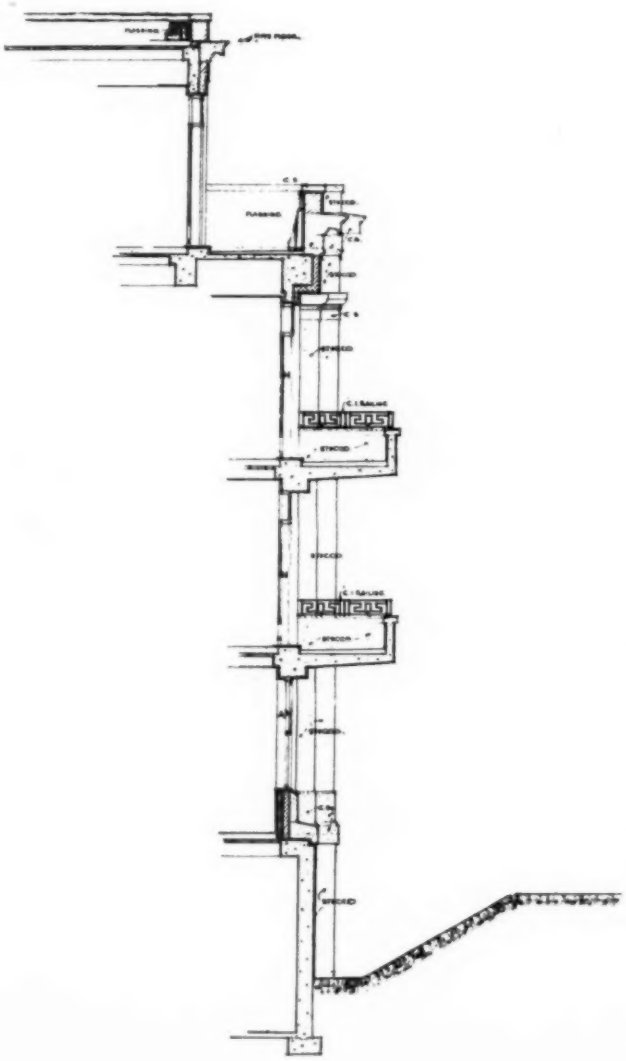
Operating Rooms: On top floor of service building; isolated, quiet, no through traffic; size of major operating rooms 17 by 19 feet; separate operating room, which can be darkened, for head work; air conditioning equipment; complete

Plan of the second floor of the patients' building.





A bird's-eye view of the Meadowbrook Hospital as it will appear when the entire plan of expansion has been carried out is shown above. At the left appears a cross-section of the balconies of the patients' building, showing details of construction.



equipment for sterilization of dressings and for both dry and wet sterilization of utensils and instruments; supervisor's office; instrument room; anesthesia room; recovery and dressing rooms.

Labor and Delivery Rooms: Temporarily located at one end of the operating floor, but open off isolated passage and independently equipped. (This is purely a provisional arrangement; eventually labor and delivery rooms will be removed from operating rooms and will be in suitable physical relation to an expanded maternity service.)

Contagious Building: Initial capacity thirty beds; can be expanded by extension of central section without duplication of service rooms; eventually the entire building is to be duplicated. All patients' accommodations on first floor; admission department so arranged that patients can be distributed to ward subdivisions without confusion or unnecessary contact; largest single ward has four beds, with individual cubicles; numerous single and double rooms; each ward and room has its own water supply and toilet facilities; nurses' station, supply rooms, diet kitchens, and dish sterilizing room so located as to minimize nurses' travel; detention room for cases of doubtful classification adjoins admitting room; minor operating room; visitors' lobby; separate bathing and dressing units for (a) incoming patients, (b) patients about to be discharged, (c) doctors and (d) nurses.

Sections of the patients' floor can be opened or closed according to need. Central kitchen on ground floor can be used more economically as service room, receiving prepared food from main kitchen, when contagious cases are few; adjoining the kitchen, on the ground floor, are dining rooms for nurses and help. Sterilization of mattresses, linens and patients' clothes, morgue, storage space, room and bath for resident cook, porter or maid, also on ground floor. Building framed for future second story over central section, to house nurses on contagious duty.

A Genuine Community Institution

Nurses' Home: Present construction includes one section of a building to be completed in three stages. Recreation and teaching rooms occupy half of first floor. Second and third floors are typical; each floor has central sitting room and two major plumbing stacks, conveniently distributed; showers and tubs; end rooms (larger than typical central rooms) arranged in pairs with connecting baths. Building framed for additional story of bedrooms. Present construction includes loggia at fourth-floor level.

Laundry, Help's Dormitory, Garage: Composite building with well lighted laundry placed at basement level to facilitate traffic; connecting corridors communicate with all related hospital buildings; space reserved for added future equipment. Garage accommodates four vehicles; yard remote from wards. Three dormitory floors; building framed for additional future story; dormitory floors divided at the middle to provide separate quarters for the two sexes; living room for each group adjoining entrances on first floor; bedrooms for domestic employees do not face wards or nurses' quarters. On the completion of the larger hospital, this building will be assigned to one sex and a smaller structure erected for the opposite sex, in the location assigned to it in the general plan.

Power House: Boiler capacity sufficient for present needs; plan provides for future expansion. Electric current to be supplied for the present by Public Service Corporation. Building includes machine rooms, various repair shops, engineer's office. Incinerator connected with main stack. Stack well north of patients' buildings (prevailing summer winds are from the south).

The board of managers composed of the Hon. George L. Hubbell, president, Col. A. S. Dwight, H. L. Hedger, Joseph J. Kerrigan and Dr. Benjamin W. Seaman cooperated in every way possible with the architects and the consultant. Holding office under the county board of supervisors, the board of managers, a volunteer group composed of citizens of the highest type, has undertaken the task of erecting, equipping, organizing and directing Meadowbrook Hospital and has aimed to create an efficient county health center. The board has followed the planning of the hospital with the utmost care and has passed upon all crucial matters of policy and program. Meadowbrook will give to Nassau County its first public general hospital, its first and only wards for the care of contagious diseases, its first public out-patient service, an emergency service of which there is great need, and observation wards for mental cases. Meadowbrook will also provide laboratory facilities for the local medical profession, and will take an active part in the social hygiene movement, in contributing to the care of chronics and convalescents, in graduate medical instruction and probably in the training of nurses. In brief, it will aim to do everything that was stressed in the course of a well directed campaign of education, ably conducted in a spirited and highly intelligent manner under the direction of the local medical society, which prompted the voters of the county to sanction the project of building an up-to-date county hospital.

Acknowledgments are due to H. Hall Marshall, to whom the development of mechanical plans and specifications was entrusted and who has been indefatigable in his efforts to provide a thoroughly modern plant, and to Alexander D. Crosett, who acted as structural engineer.

A "Benefit Without Cost" Is Unique Method of Raising Money

What was designated as a "Benefit Without Cost" was sponsored recently by the Neurological Institute, New York City.

An attractive and unique announcement was sent to friends, both real and prospective, of the institute, with the following wording:

"Last year we gave our first Unattended Benefit. The response was generous and all the money was used directly for the care of poor patients.

"The costs of a theater benefit reduce the net proceeds by 40 per cent.

"We need help.

"In 1931 the operating deficit of the hospital was $100,000. In 1931 the free care given amounted to $87,000.

"Will you give the equivalent of a box or as many tickets as you can?"

Enclosed with the announcement was a card bearing a list of prices of the cost of boxes and seats to the subscribers to the Unattended Benefit.

Lessening the Small Hospital's Accident Case Losses

By JOSEPHINE E. THURLOW
Superintendent, Cambridge Hospital, Cambridge, Mass.

IN THOSE states where social laws work an injustice to such vested interests as hospitals, the existing situation must either be accepted or else some legalized method of "offset" must be adopted. In the latter situation the method of "offset" should be carefully planned, all pertinent information gathered and a long and tactful siege determined upon.

It is commonly held by that group of hospitals classified as philanthropic that funds left for charitable purposes should not be diverted for the benefit of any organization maintained for profit. Profit making organizations include insurance companies and contract work with certain agencies at rates lower than the cost of service.

What the Supreme Court Has Ruled

Under the rulings of the United States Supreme Court it appears that legislatures have no right to fix rates for service not impressed with a public interest; that service rendered by hospitals is not so impressed; that legislatures, or state boards, or officers acting under legislative authority, may not fix rates below the cost of service rendered.

With the acceptance of the foregoing opinions as equitable, the basis for the following procedures is obvious, and while it may apparently work a hardship upon the patient or appear to increase the hospital's deficit, in actual practice it does neither. The hospital should:

1. Hold the patient or his legal guardian solely responsible for the hospital's service to him.

2. Decline all financial transactions with insurance companies except when on terms specified by the hospital, in which instance it should take no steps until the insurance company has supplied a written guarantee covering the hospital's terms.

3. Send no bills to an insurance company except by the company's written request, in which case the bill should cover the regular hospital charges in full. Either a form letter should be enclosed or else there should be entered on the reverse side of the bill information to the effect that "this bill is sent at your request" or "at the patient's request" and that "the hospital holds this patient responsible for services that have been rendered to him."

4. Accept no check from an insurance company, no matter how temptingly large the amount, which does not entirely cover the hospital charges. It should be returned with a form letter. (In time the local insurance company will have accumulated many of the hospital's letters but they may keep on "trying the hospital out.") If the check is in full and the hospital accepts it, the patient should be asked to sign a "Request for Acceptance" form.

5. When an insurance company desires the services of the hospital, as the wiser investment for its (the company's) own interests, the hospital should obtain the company's written guarantee of full payment for each in-patient or out-patient. The difficulties of carrying out this system must be anticipated; they will, however, gradually decrease. The advantages are twofold: (1) The hospital loses no more in financial returns than would be lost through services to "nonpaying" patients who do not come under the Workmen's Compensation Act, or when the judgment is not in favor of a patient in the "nonpaying" class; (2) the value of tactfully pursuing a policy that educates the industrial leaders or employers of the locality has a noticeably beneficial effect on payments "in full."

Analyzing the Situation

In a consideration of the rights of all groups concerned, there should be borne in mind the analysis of the situation made by Dr. E. H. Downey, who said, "From the modern democratic standpoint the test is one of minimum social cost: that distribution of unavoidable losses is to be preferred which imposes the least hardship upon individuals and results in the smallest diminution of the communities' economic assets." Doctor Downey goes on to say, "The principle of compensation is most conveniently and effectively applied by treating the economic cost of industrial injuries as a direct expense of production in the same category with wages, machinery and materials. The employer in our entrepreneur system of industrial management is the keeper of the purse; it is his function to assemble the instruments of produc-

tion and to include the expenses thereof in the price of the product. He will protect himself by insurance against unusual loss and will incorporate the cost of industrial injuries in the price of vended goods and services."

The Hospital's Side of the Question

These conclusions are quoted for the following reasons: Doctor Downey is nationally acknowledged as an outstanding authority on workmen's compensation; in carrying out an educational program in this field, the first objection encountered is usually a statement by the manufacturer that if hospital costs are to be paid in full, this will increase his insurance rates, he will have to compensate in charging more for his product, and competition is so close he cannot do so; in an industrial center the hospital is unquestionably one of the community's soundest economic assets. All discussions between employers and the hospital should be carried on by the superintendent or by thoroughly informed assistants to whom this responsibility has been delegated in the superintendent's absence. Time and patience are required to educate the manufacturer to accept the hospital's point of view; he does, however, readily see that to direct charitable funds for "outside" profit lessens the amount of free service available and increases the taxes to such an extent that it becomes necessary to apply for city aid to care for surplus patients and in turn he reimburses the city through his increased taxes.

The objection is raised that under such a system the hospital must wait for its pay if the patient is too poor to meet the bill.

Is there any insurance case of the type herein discussed where the hospital does not wait for its pay—two years possibly—until the case has gone before the state industrial accident board? The hospital will wait either way.

If the patient's claim is approved the bill is then paid in full by the patient in the majority of cases. With the occasional "bill dodger," the hospital's attorney should be ready to bring suit against the patient at once.

This, by prearrangement, should not involve a loss of more than 25 per cent of the hospital bill and approximates a similar loss, if not more, in transacting business with an insurance company on the basis of most existing laws which fix the rates at less than the standard hospital rates.

There is less dissatisfaction in diverting the 25 per cent to the hospital attorney—he has earned it—and considerable satisfaction in living up to a right principle and in taking another step forward in educating the community to an existing injustice.

This method would not be practicable for hospitals averaging more than 2,000 casualty cases a year or for hospitals in large urban centers. The time involved might offset the financial saving, and the connections between industrial organizations and the hospital are not so closely related. The method outlined is slow but sure.

Education begins with the hospital's governing board, extends gradually to local employers and members of the chamber of commerce and must, in time, bring sufficient pressure to bear on resident members of the state legislature to result eventually in a law that does not bear the earmarks of class legislation.

Hospitals for the most part, share largely in the employer's financial responsibility for injured employees but they have no part in the profits accrued to the employer by the product of labor.

Hospitals keep down the employer's cost of production and increase the profits of insurance companies.

No bibliography has yet been prepared in relation to this nationwide hospital problem; the following references will serve, however, to set forth the situation at the present time.

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Fewer Chicago Babies but More Born in Hospitals

About six thousand fewer babies were born in Chicago in 1931 than were born in 1930, according to figures recently published by Dr. Herman N. Bundesen, city health commissioner. Incidentally, fewer Chicago babies were born in homes than in hospitals, the figures show.

In 1930, 58,083 babies were born in Chicago—39,470 in hospitals and 18,613 in homes. In 1931, this number had decreased to 52,993—37,250 in hospitals and 15,743 in homes.

Of the relative proportions of Chicago babies born in homes and in hospitals since 1926, Doctor Bundesen presents the following percentages: in 1926, 55 per cent of the babies were born in hospitals; in 1927, 59 per cent; in 1928, 62 per cent; in 1929, 64 per cent; in 1930, 68 per cent; in 1931, 70 per cent.

These figures, it is pointed out, are almost the reverse of general statistics throughout the country, which is approximately 70 per cent in the homes and 30 per cent in the hospitals.

Buying and Selling as Seen by a Salesman

By PLINY O. CLARK
Great Falls, Mont.

"TELL that ——— salesman I'm busy." This remark was made by a superintendent of a church hospital and, unfortunately, was overheard by a salesman. It contains food for thought. First, it shows a lack of understanding on the part of the superintendent or buyer as to what benefit he may derive from a salesman and, second, it reveals a poor selling technique on the part of an earlier salesman who may have been handicapped by an unpleasing appearance, inadequate preparations or a negative personality. At any rate there was antagonism where there should have been understanding between buyer and seller.

In the very nature of hospital business, the buyer, whether steward or superintendent, must interview salesmen, since it is not always possible for him to visit the store or the factory to make a personal selection of equipment or supplies. The salesman, therefore, should be a happy medium both for buyer and seller. Toward the buyer, the salesman should act as an expert authority on the quality, the fabrication and the use of his company's goods; he should understand the buyer's needs and temper his recommendations to fit those needs. Toward the salesman, the buyer may well direct perfect frankness mixed with adroit questioning. In this way the best side of the salesman is brought out and valuable information as to the product in question is obtained.

Various Methods of Buying

In large hospitals, buying may be reduced to a science if it can be directed by a person of experience. Such a purchasing department will have files giving definite specifications for each article to be bought, these to be changed as requirements change or altered to keep up with the times. In a parallel file, prices will be kept up to date and a running inventory of stock will be available. These are some of the fundamental requirements of a satisfactory buying department.

The majority of hospitals, however, in the absence of a well directed buying department, must depend upon a superintendent encumbered with the countless details of institutional management or possibly upon a dietitian whose activities lie in another direction. Again, the buying may depend upon the superintendent of nurses who already has more than her share of responsibility in looking after the nursing part of the problem. In such cases, the buying is anything but scientific. The reason given for buying usually is as follows: "I liked the salesman so I bought it." Or, "It was the cheapest thing I had seen."

The Evolution of the Salesman

Rumor has it that the traveling salesman as such will disappear one of these days. Perhaps that rumor will become a fact with the greater use of the radio, of television and other scientific marvels. Since, however, the much maligned traveling salesman is still with us, possibly a bit more information about this person may not be amiss.

In the earlier days, a peddler took a pack of goods on his back and sold them from door to door. The goods sold, he had money with which to purchase more goods and, if lucky, a certain profit with which to meet a few of his personal necessities. From that day to this, the same fundamental requisites for salesmanship remain. The manufactured goods must be sold. The buyer needs certain products. The joining of the two needs is the business of the salesman. With the ever increasing speed with which we are moving, this job is no mean task, for knowing the article and its price today is no assurance of the morrow. The salesman must be alert to momentary changes on the part of buyer and manufacturer alike. He must know more than price. Use, service and end results all require attention, not to speak of the "psychology of selling."

Salesmen are employed in many ways, usually on a small salary with an allowance for traveling and hotel expenses and with a commission for amounts sold over a minimum quota. Again, there may be a salary without commission, but with an allowance for running expenses. Then, there may be the straight commission form of payment when the salesman pays all expenses and receives a

commission only on what he sells. In any event, the expense incurred must be met from the sales made and, when the expenses exceed the profits made, the salesman is the loser.

All of this means that a salesman, if he is to succeed, must usually sacrifice a home. He must be at the beck and call of seller and buyer alike. He must possess enthusiasm, personality and a knowledge of his goods. He must have a pleasing personal appearance and he must be well groomed. Last but not least he must be able to obtain the dotted line signature.

What Each Means to the Other

If we were to believe the usual stories about "traveling salesmen," we should suppose them to be wastrels, frequenters of night clubs altogether and generally "no-account" fellows; yet we realize that ability and success do not show through such channels in this work any more than in other work.

Are there then a few generalizations in which we may indulge in this happy meeting of buyer and seller, since each seems necessary to the welfare of the other?

First, with the buyer or superintendent, it is well that certain definite standards or specifications should be set up as to the quality and the amount of each article to be kept on hand. Having determined these points, the superintendent would then be wise to establish standards in buying—that is, when and how to buy. Certain seasons yield the best prices in some lines while with other articles the prices have to be followed from day to day or from week to week. A good buyer is that one who purchases quality consistent with the best price obtainable. So, having the right specifications, the best prices and an inventory of stock, with a definite method of buying, the buyer should make the most of each master salesman—learn from him and keep an open mind on quality, service and price. Even if there is no prospect of an immediate order, the superintendent should receive the salesman courteously anyway and expect the same treatment in return.

Second, the salesman should strive to fit himself as a master salesman in every particular. He must watch his appearance and greet every buyer with a smile no matter how lonesome or downhearted he may be. He should enter the buyer's office with enthusiasm and leave with the knowledge that he has created a good impression. He must impart knowledge, not bare statements. Neither must he waste the buyer's time nor his own. He should be resourceful and to the point, refusing to stoop to the slightest criticism of his competitor or his competitor's goods. He must study his buyer, learn his wants and his needs and endeavor to satisfy them. A request for samples, for reports on tests or for further information must never be overlooked.

A Michigan jobber recently suggested that the following be used as daily tests by his salesmen:

1. Was I physically fit?
2. Did my personal appearance bespeak prosperity or success?
3. Did I make sure that my approach was well timed, and did I make proper efforts to avoid interruptions?
4. Did I at least make an effort to discover a possible angle of approach to the customer?
5. Was my greeting sufficiently cordial, businesslike and important? In other words, could I have made a better impression?
6. Did I waste too much time with nonessentials? Or was the customer's personality of such a nature as to justify talk of nonessentials?
7. Did the prospect's coldness weaken my approach? And did I allow this coldness to develop to the point of resistance?
8. Was I sufficiently alert to gather from this approach any suggestion regarding the best method of putting my proposition?
9. Did I carefully watch for a spark of interest and remember the point which obviously aroused interest, and did I come back to the point and elaborate upon it?
10. Did I quickly discover the one objection which would have to be removed before the sale could be made?

In a word, courtesy and consideration on the part of both buyer and the salesman should mean larger profits for both.

A Fifty-Year Fight That Brought $3,000,000 to One Hospital

After court suits that have extended over a period of fifty years, the Pennsylvania Hospital, Philadelphia, was recently awarded $3,000,000 in Orphans' Court, says the *Philadelphia Inquirer*.

Alexander J. Derbyshire in 1879 left $300,000 in trust, providing annuities for three relatives. Since the annuities were the only sums paid out of the estate, it now amounts to $3,081,531. The hospital tried twice to get some of the money—in 1880 and in 1913—and failed. On April 14, 1931, however, the state legislature enacted a bill providing that a court might terminate a trust fund provided in any will made prior to the act if all parties affected agreed. The trust under Mr. Derbyshire's will was therefore terminated by the payment of the more than $3,000,000 to the sole surviving legatee.

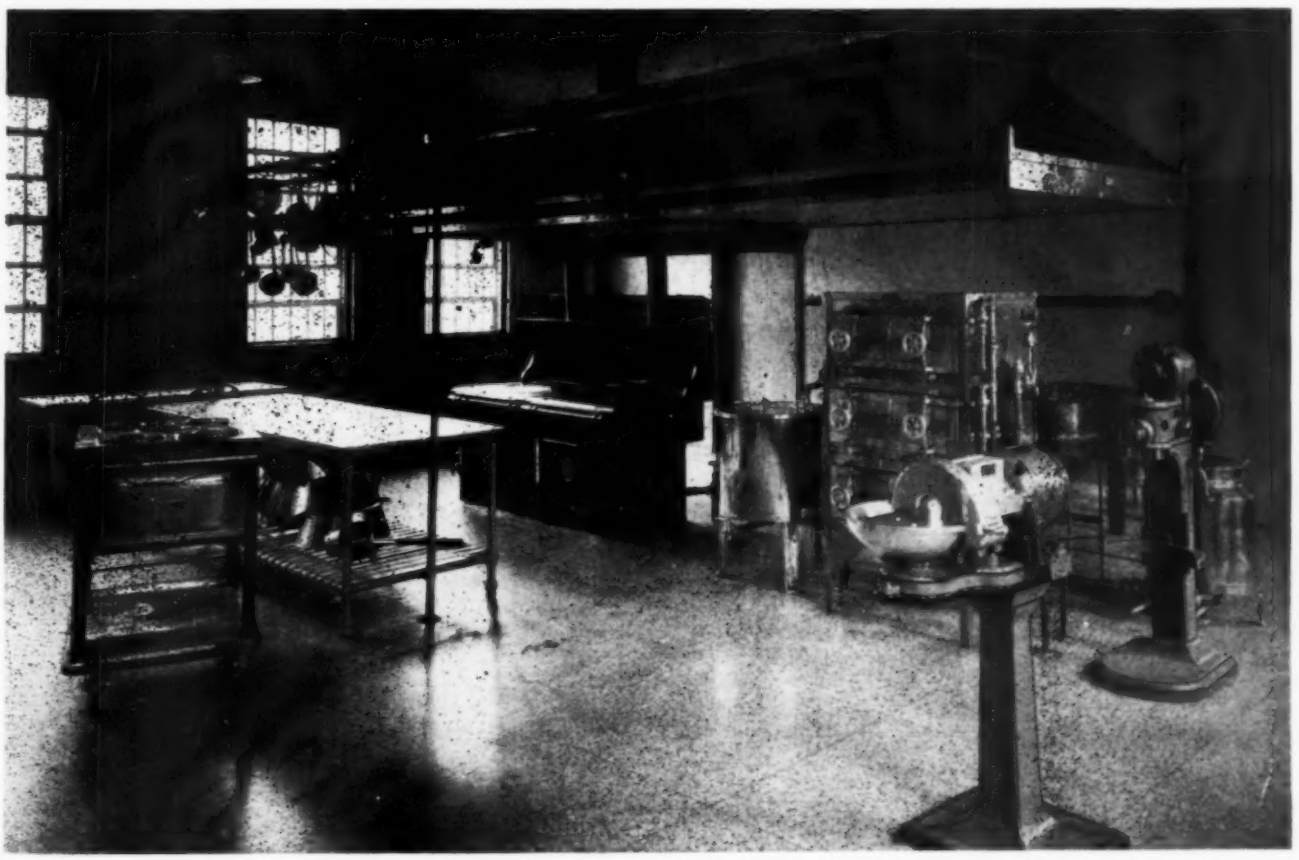
Striving for the Ideal in Food Service

By F. A. CARMICHAEL, M.D.
Superintendent, Osawatomie State Hospital, Osawatomie, Kan.

THE proper distribution and service of food in a large institution is only one, though a major one, of the problems of hospital administration. Like nearly all the other problems of hospital management its solution depends on several factors, which may be mentioned in the order of their importance, as follows: (1) organization, (2) physical equipment, (3) the proper selection of foods, (4) adequate sanitation and (5) an ideal.

A discussion of these factors must take into consideration the fact that the hospital executive cannot be a chef, a master mechanic, an engineer, a brick mason, a landscape architect or fill all of the other positions required in an efficiently operated institution. Therefore, if successful and satisfactory service is to be achieved his subordinate personnel in these various departments must be endowed not only with the skill of their craft but with executive capacity, pride of achievement, resourcefulness and cooperative spirit. Possessing these, the subordinates must be permitted to exercise their individual judgment and initiative in deciding the matters in which their particular department may best be perfected.

In the opinion of many who have for a long time been in contact with hospital kitchens, the preparation of palatable food and its proper service is becoming a lost art. This is largely traceable to certain factors, such as the tendency of the employee in the kitchen and elsewhere to reduce time on duty and physical effort to a minimum; force of habit and a strong distaste for adopting new methods; inefficient assistance; inadequate physical equipment which increases and handicaps the efforts of kitchen help; lack of critical judgment in the purchase of food supplies on the part of purchasing agents who only too frequently see



This kitchen was designed to prepare food for 200 patients. Hot food is distributed to the patient floors in thermal carts like the one shown at the left.

nothing beyond the price mark in the supplies they provide, and the tendency of bidders to submit substandard food at prices that appear attractive to purchasing boards. Thus the purchase of inferior grades of spices, extracts, canned goods, meats, sugar, flour and vegetables is the rule rather than the exception. Proper equipment is often lacking for conveying food to wards and tables at the proper temperatures and in institutions devoted to the care and treatment of mental cases, too few employees are assigned to the kitchen service.

Monotonous Menus Kill the Appetite

In no department in the hospital organization is intelligent cooperation more necessary or more appreciated than in the kitchen and dining service, and no department demands more in the expenditure of judgment and conscientious effort on the part of its personnel. Half cooked, unseasoned, cold or unattractively served food discourages the appetite of even the most robust and vigorous person. A fixed rotating weekly menu has the same effect. If we know that we are to have beans on Monday, stew on Tuesday and prunes on Wednesday, we are apt to develop a distaste for the fixed daily menu in advance of its service.

It is argued by some that the preparation of food in large quantities precludes the possibility of serving it as attractively as when it is prepared in smaller amounts for fewer people. This is a fallacy. The greatest difficulty encountered in achieving satisfactory food service lies in the fact that a large share of those purporting to be cooks are without pride in their calling and do not regard the preparation of food as an art but consider it merely as a job to be performed perfunctorily with as little effort as possible. They do not thrill to a sense of worthy achievement, but have in view only the weekly or monthly check. Most of them are prompted by an honest desire to render efficient service but fail to realize that a good cook for a farm or a lumber camp falls far short of meeting the requirements of a hospital. On the other hand, the supertrained and high-powered dietitian who knows more about calories than the man who first named them is frequently so lacking in common judgment and horse sense that she is apt to be a liability rather than an asset.

The cook who is convinced that baked potatoes should be set out to cool for half an hour before being served, or that coffee should be boiled for at least an hour is as acceptable as the dietitian who knows all about vitamins, carbohydrates and caloric values and has an imposing diploma, unbounded confidence in herself and a vast practical inexperience.

A satisfactory workshop is necessary if the cook is expected to produce results either in economy or in service. The kitchen equipment throughout should be of material that will offer the least impediment to absolute cleanliness. Floors and side walls in particular should be of materials and construction that will withstand daily scrubbing. Ample light, free ventilation, proper provision for drainage and modern refrigeration methods are the first essentials. Ranges, steam kettles, roasters, urns and other cooking equipment should be chosen with proper regard for outward appearance and the ease with which they may be kept clean and polished. We have found the noncorrosive metal jacketed fixtures admirably adapted to our purpose, and prefer this construction to the vitreous enamel kettles for rough usage and prolonged wear. Modern labor saving equipment, such as food choppers, potato peelers, egg and potato beaters and dishwashers, while for long viewed with suspicion and distrust, have proved their worth and economy after critical trial. Their presence in the kitchens lends importance and completeness to the ensemble, stimulates the pride of the chef or cook, lessens drudgery and gives more time for a consideration of problems of food preparation.

In short the kitchen must be made attractive and planned for efficient management. Cooks usually do not complain of their task of cooking but object to spending the major portion of their time supervising the cleaning up process that follows a meal, when the surroundings are dismal and grimy and the utensils unsightly.

Measures of Economy and Convenience

A major part of the funds expended in the operation of the larger hospitals goes for food service, therefore every element that may contribute to the efficiency or economy of this department is of vital importance. Inadequate refrigeration has perhaps been responsible for more waste and loss than any other single factor. All ranges and kettles should be placed under a single canopy. Steam and odors may be removed by a small exhaust fan so placed as to remove them directly from the canopy, thus avoiding the accumulation of moisture and grease on the ceiling. The use of noncorrosive metal for stock pots and other large cooking containers has been found satisfactory because it is durable and easily cleaned.

Proper coordination of the preparation and service of foods must be maintained. Food that leaves the kitchen warm and appetizing is frequently cold and clammy by the time it reaches the patient on the next floor. This may be obviated by the use of electrically heated thermal carts, which

are in reality mobile steam tables. These are usually plugged into sockets half an hour before the meal is ready to serve and preheated. When the food is ready for transfer, the containers are filled with hot food and the cart is moved to a diet kitchen or a distant dining room. It is again plugged in and the food is kept hot and appetizing for any desired period. This type of equipment is not standard but is constructed to meet the needs of the hospital for which it is designed.

The average man executive knows less about the organization and maintenance of a proper food service than about any other department under his direction. Consequently the supervision usually falls under the direction of a matron or a housekeeper. Her capacity is directly reflected in the quality of the food and its service.

Several years ago I sought the assistance of an experienced hospital head in finding a good matron. He looked at me sadly and said, "Son, they're like Santa Claus, there ain't no such animal." His pessimism was the outgrowth of years of disappointing experience. Many hospital heads share the same view. In most instances, however, the failure to secure reasonably satisfactory results in food service is due to the fact that kitchens are carelessly supervised. No fixed and definite standards are set except perhaps that meals must be prepared and served on time. When a definite standard of efficiency is established it requires in most cases only a minimum of supervision to maintain that standard. Kitchen help must be given a clear understanding of the fact that all food, no matter how simple, must be carefully prepared, thoroughly cooked, properly seasoned and that almost every article of the ordinary hospital dietary may be prepared in a variety of ways without additional expense, thus avoiding a monotonous and routine service.

Domestic and serving help must be made to feel the necessity for a proper and appetizing display of food, for after it leaves the kitchen the cook's responsibility ends. Food must not be dished up and allowed to cool if its palatability depends on its temperature. It should be placed before the patient in as attractive a manner as possible.

In general hospitals where extensive tray service is necessary, the expediency and wisdom of making trays attractive is recognized. If tastefully and daintily served a small piece of toast and a cup of tea will be accepted by even a hungry patient without protest, while a more varied, expensive and elaborate serving carelessly prepared and served in a slovenly manner excites resentment and disgust on the part of the patient, and is remembered long after other experiences of hospital residence have been forgotten.

In this larger kitchen food for as many as 800 patients can be prepared.

In hospitals where special types of ailments are treated, such as mental hospitals, it is argued that extreme care and pains are unnecessary as many of these patients are so clouded mentally or have progressed so far toward the vegetative stage that they are insensible to the quality or appearance of the food with which they are served. This argument holds good only for certain classes, always in the minority. These patients' beds are made painstakingly, they are dressed carefully and they are kept as clean as the less clouded types. Why should not our solicitude extend to the service of their food which is the only thing in life that most of them are capable of enjoying?

The selection and purchase of proper food does not present the same problem for the small hospital, say of fifteen to fifty beds, as it does for the

larger hospital of 1,500 to 2,000, but the same general principle applies to both, that is, that careful and critical buying is essential. Hotels and restaurants catering to from 1,000 to 2,000 guests use the most rigid system of inspection of kitchen supplies purchased. They have found by experience that inferior supplies produce inferior food, and although they purchase large quantities on standing orders, inferior supplies are always rejected.

The greatest difficulty in maintaining a satisfactory food service is encountered when the purchasing agency is not in intimate touch with those who prepare and those who consume the food, especially when supplies are bought on a contract basis on competitive bids. In such cases the most rigid specifications are frequently evaded by the contractor, for as a rule those concerned in the preparation of food know nothing of the quality of the samples on which the award was based. Half packed canned goods, half trimmed hams and loins, tough stringy beef carcasses without an ounce of fat, lima beans with celluloid outer coverings and steam resisting centers, cereals full of weevils, currants that are half gravel, these and a thousand other annoyances result. Whenever cheap and inferior supplies are used, the waste, slops and refuse increase, and whatever economy might seem to accrue from the purchase of inferior food supplies is swallowed by the increasing waste in serving.

The problem as may be readily seen is solved by a proper plan, critical maintenance and painstaking supervision.

Every hospital has its ideal as to service in each of its departments, but the food service is apt to receive the least serious study and attention. Instill in your food service department a proper pride and a proper ideal and you will be surprised at the happy response it will bring.

Medical and Hospital Care in Vermont Studied

The "poor" do not receive necessary medical care, at least in so far as is shown by a typical study in Vermont, published by the Committee on the Costs of Medical Care.

It was found that at least 30 per cent of the money expended was wasted because of self-medication or inferior practitioners. More than $7,500,000 is expended annually in Vermont, more than $2,000,000 of which is wasted, it was explained. It was further discovered that 70 per cent of the people studied had no dental care of any kind during the year.

Vermont was chosen for study because it was considered representative of agricultural New England and other historically mature communities, and because its problems, as the report repeatedly points out, are fairly typical of a substantial part of the United States.

What the Survey Shows

Other striking facts revealed by the survey include:

1. Costs of sickness to families are distributed unevenly, the annual expenditure ranging in the families studied from fifty cents to $1,400. Of approximately 1,300 rural families intensively studied, 17 per cent paid 62 per cent of the total costs incurred by the entire group.

2. Mileage charges by doctors for visits to outlying districts, usually fifty cents a mile one way, in addition to the fee, intensify this unevenness, and dispose farm families to put off calling the doctor.

3. No central board or agency is available to plan the provision of medical facilities according to the needs of the people; to decide, for example, whether new hospitals are required, and if so, what kinds and how large they should be, and where located.

4. Seventy per cent of the people studied had no dental care of any kind during the year.

5. In a few rural communities in the state, subsidies are paid to physicians out of tax funds, thus assisting them to earn an adequate living and making a doctor accessible to citizens in the locality. Elsewhere, physicians often have difficulty making ends meet.

6. Osteopaths average an annual net income of $4,454, an income higher than that of either physicians, who average $4,310, or dentists, who average $4,187.

7. Physicians employed on full-time salaries earn, on the average, $1,000 a year more than physicians in private practice.

8. Rural doctors utilize modern laboratory procedures but little and frequently practice without the technical advantage afforded by a hospital.

9. Though there are, in general, enough hospital beds in the state, they are not used to the extent that good practice requires. There is almost no out-patient, clinic, or follow-up activity, and the fact that at least six hospitals do not own a microscope is taken as illustrative of certain deficiences in diagnostic practice.

10. Preventive medicine is sorely neglected. There is a great disproportion between the expenditure for public health work, thirty-one cents per capita annually, and for nervous, mentally unsound and feeble-minded persons, $2.45 per capita.

Making Smooth the Way of the Social Worker

By JOAN MYERS
Medical Social Worker, Hamot Hospital, Erie, Pa.

WHAT is the recognized status of the social worker in the small hospital? And what official recognition should she have in order to do a constructive case work job? These are questions every social worker asks herself at least fifty-two times a year. She talks them over with her co-workers, but, alas, the questions are seldom discussed by the persons who could ameliorate the situation.

Large well financed hospitals accept an efficient social service department as one of the vital parts of the hospital organization. They demand a trained experienced director and an efficient corps of workers. The director of social service is a recognized department head and as such she must function. The place and part of her department in the functioning of the institution are understood. She has her advisory board, which plays a large part in her work. Her workers are assigned to a particular phase of work—to diabetics, to cardiac cases, to tuberculous cases, to psychiatric cases, to orthopedic cases, to pediatrics or maternity cases or to any one of several types of cases, depending upon the number of workers.

The Physician's Co-Worker

The social worker is not only responsible for social case work among her patients in the hospital, she must work also among her particular group in the out-patient department. She is interested in the study and treatment of diseases in connection with the social conditions and ills that may influence their fluctuation. She becomes a specialist in this line of endeavor, but she never attempts a diagnosis or prognosis. According to the ethics of her profession, she might as well attempt to perform a thyroidectomy. She is accepted by the physician as a co-worker, to aid him in his work. The two are interdependent. He depends on her for social history, social diagnosis and post-hospital care; she depends on him for medical knowledge and advice. Each has his own place—and they are side by side.

But the hospital we are interested in is the hospital with a bed capacity of from 150 to 250, a general hospital that is required to do the charity work of the city it serves and is in turn supported by the public and often the state. It is in this hospital that we place our young pioneer social worker and expect her to be a performer, not of case work but of miracles. She works under the supervision of the superintendent of the institution, who does or does not know her real function. Perhaps she has been appointed because his board wants a social worker; perhaps he, himself, feels that all up-to-date hospitals have a social service department; perhaps the community has made it a wise move for the hospital. On the other hand, perhaps he is one of those rare far-sighted individuals who realizes the real need for a social helper in the medical charity work of the hospital he represents.

What the Social Worker Can Contribute

This social worker becomes a part of the hospital organization. She is expected to bring to the hospital's problems a knowledge of community resources and a mind trained in the methods of social work. She is prepared to do this and is ready to make constructive plans for the patients of the hospital. She is eager to have cases referred to her, eager to show what her department can accomplish. Sometimes she has an advisory board, and sometimes not. Once in a while she has direct contact with the board of the hospital, more frequently she has not. Generally she has no assistance, either clerical or professional. She must choose between doing all the work that is brought to her attention and keeping scanty, if any, records, and doing a limited amount of work and keeping records on that. Nine social service workers out of ten will choose the former method and they are right, I believe, although there is an abundance of room for controversy on that subject. Every person in any kind of social or hospital work recognizes the value of complete well kept records. If the patient applies for treatment two or three or five years later, adequate information, both medical and social, on former contacts with him is of inestimable value. Yet how many social

workers in small hospitals have even part-time clerical assistance?

Practically every social worker, upon first affiliating herself with a hospital finds an air of antagonism springing up among the medical staff toward her. Until recently it has seemed that medical schools have tried to convey the idea to their students that a social worker is an interfering busybody, who dabbles into everybody's business, is unduly talkative about the other person's troubles and who claims complacently that every woman and girl is either delinquent or feebleminded and that all members of the masculine sex are "no good."

A Feminine and Understanding Group

Surely that picture of the virtuous world reformer cannot be accepted by intelligent men and women today. In the many hospitals that have social service departments it would be difficult to find the proverbial, masculine hyperbusiness type of woman in tailored suit, high collar and broad brimmed hat. Social workers, almost without exception, are a feminine group, interested in people and thus in their work, since it is purely with people and their problems that they must deal. They are an understanding group who recognize mental inferiority when it appears but do not go out in search of it. They enjoy all people of both sexes because they are human beings and not so many laboratory specimens for exhibition. Hardly can it be said that they choose social work from a mercenary point of view, because it is one of the lowest paid professions.

If the hospital expects the social worker to do constructive work that it may be proud of, it must organize its departments accordingly. If superintendents of small hospitals do not recognize the need of a medical social worker they should find out the function and use of such a person before she enters as a more or less unwelcome member of the organization. They must want her, they must know how she can assist and further the good work of their hospitals before they employ her. And then when they or she, together or apart, plan the organization of the new department, the scheme of the larger hospital must be followed on a smaller scale. She should visit large hospitals from time to time, so that she may keep in touch with their methods. In fact, it might be worth while for executives to take a side glance that way now and then.

The superintendent and the social worker together should outline the work of the department. The worker should be given the authority of a department head. There should be restrictions as to the types of cases that are referred to the worker. She is but one person. The most important cases must be chosen, those in which her service can be most effectively utilized. Perhaps in one hospital the most glaring medical-social problem may be the proper disposition of the chronic patient; in another it may be how to do constructive social service work among pediatric cases.

The social worker must have clerical help, even if only part time. A clerical assistant will be her greatest asset, and if the assistant is the right type of person she may in time assist in more than a clerical line. The social worker should be provided with an advisory board of men and women, socially minded individuals of the community, with whom she can meet at regular intervals to discuss the social problems of the department and to encourage an interest in the hospital among laymen. The women of the board may be chosen from the women's auxiliary of the institution. The worker must be encouraged and aided in this educational program, since her first interest is in the institution she serves and represents. The superintendent must also bear in mind that the public, the board of managers, the auxiliary, all must be enlightened as to the "why" of this addition to the corps of employees. If the social worker has the ability to do so, she should be encouraged to address clubs and community gatherings as often as the opportunity presents itself.

As for the staff of the hospital, it should be acquainted immediately with the plan, scope and function of the new department. A joint meeting could be arranged, shortly after she has arrived, of staff, board and auxiliary members and the entire assemblage informed of the plan of action to be pursued.

Growth Should Be Noticeable

Finally, when the educational and working program is under way the standards of other hospitals should be kept ever before the worker. The social worker's goal should be an efficiently functioning department. She should have always unattained heights toward which to strive. If the department grows easily and naturally, as it should, there will not at the end of five years be only one worker, with no assistance, professional or otherwise.

This is not a complaint against the medical profession, against hospital executives or in fact against anyone. It is a plea for cooperation with and for an understanding of the social workers who are employed by hospitals as persons capable of a type of work that will keep the physicians from having to repeat and re-repeat their work with the patients.

Why Going to School Is a Pleasure for These Nurses

By L. A. SEXTON, M.D.
Superintendent, Hartford Hospital, Hartford, Conn.

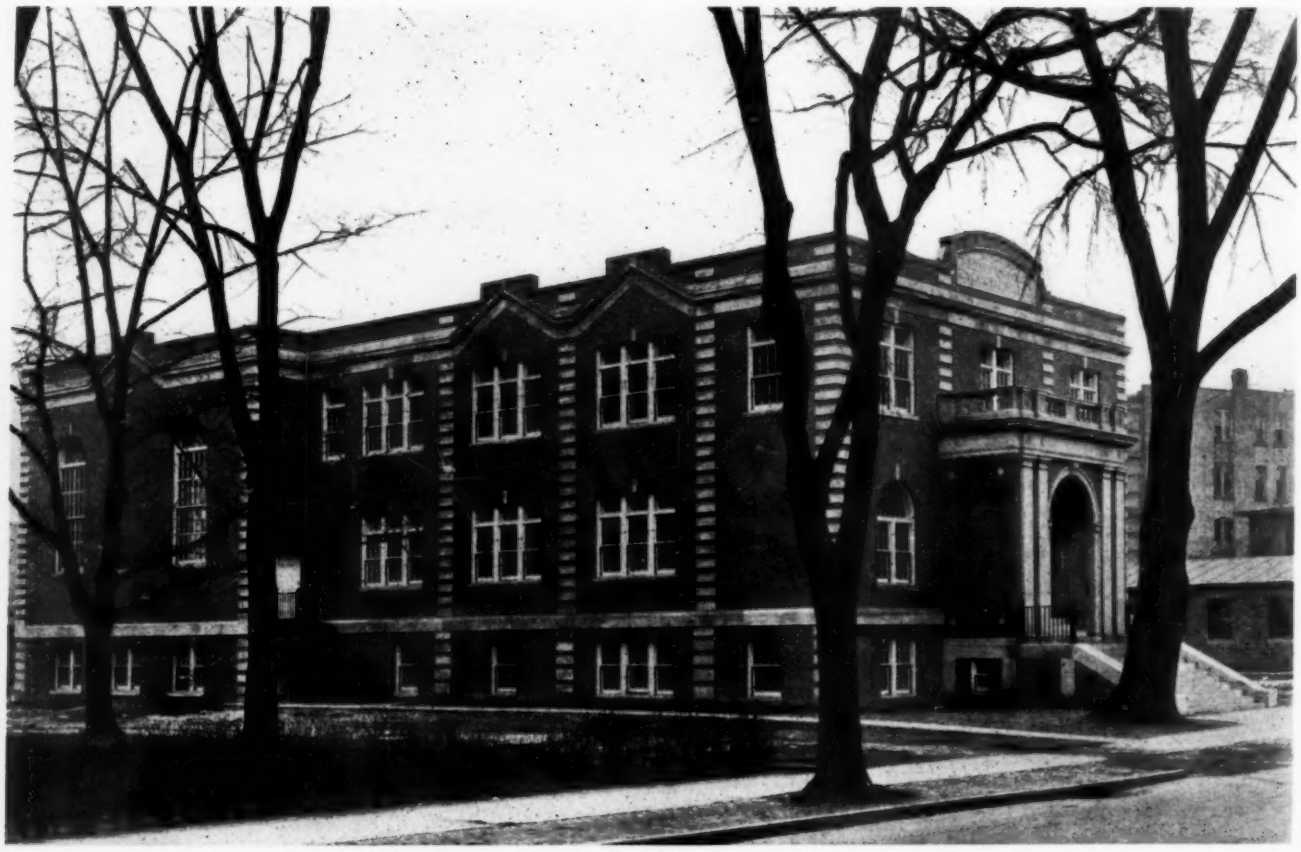
DURING the past twenty-five or thirty years the education of nurses has been more or less in a state of flux. The apprenticeship method of training has predominated throughout the years and for the general duty nurses will probably remain the method of choice. In recent years many of the heads of the larger schools have felt that the academic side of the nurse's training has been overemphasized.

Best Facilities Should Be Available

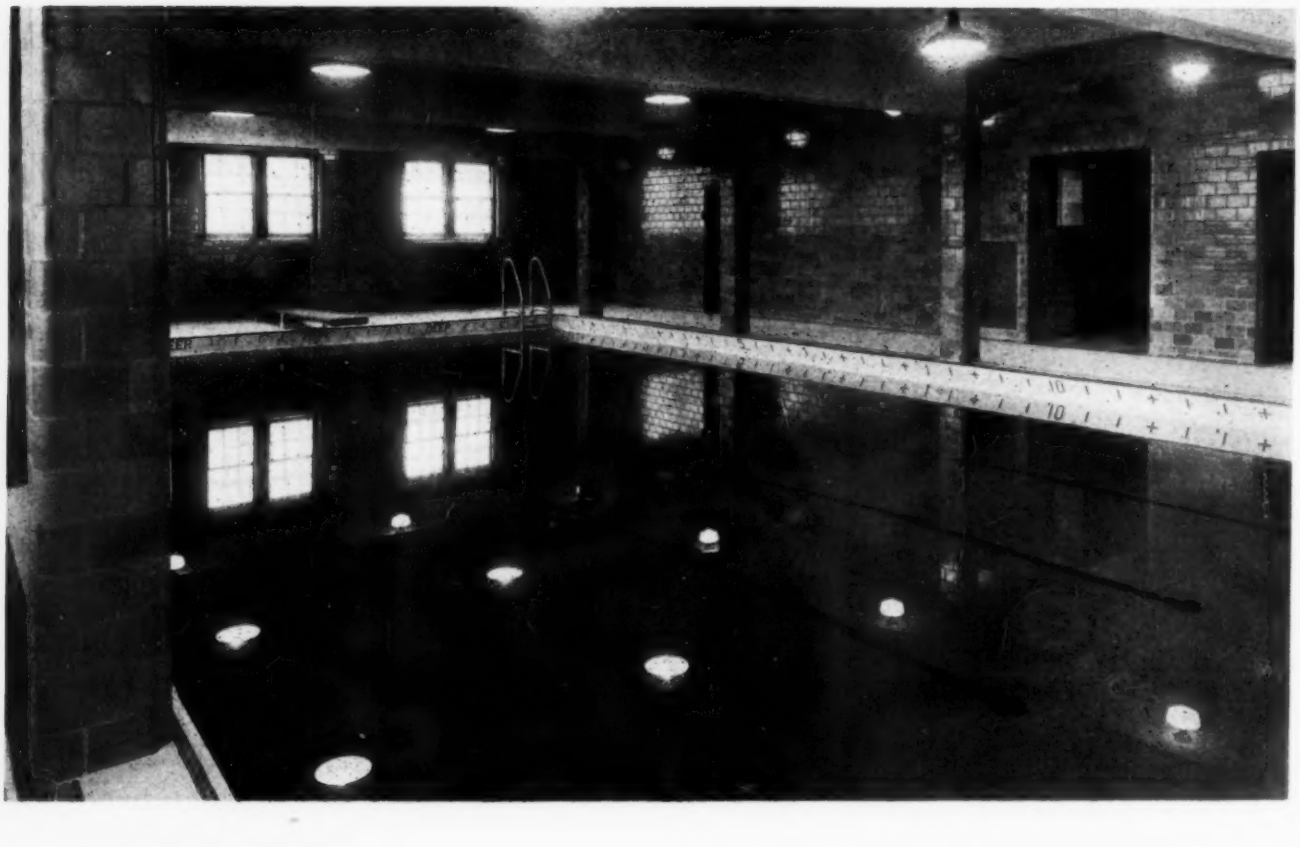
With the raising of the standards of existing medical schools and the discontinuance of many of the smaller schools, the physician no longer has any desire after eight or ten years of preparation to return to the rural districts to take up the laborious duties of the old-time practitioner; the same is perfectly true of the nurse who feels that to become a general duty nurse is a step lower in the profession than she should be expected to go after going to college and then taking her training in the nursing profession. Perhaps this is true, but to the man or woman who is ill enough to require the services of a nurse the question of degrees means little. If the proponents of the academic training of our nurses doubt this, let them get sick (once is enough) and they may then get the slant of the rank and file who make the demands upon our hospitals for nursing service.

This is not the time or place, however, to discuss the various methods of training or their relative merits whatever they may or may not be. If we are to go on training nurses, and the probability is that few training schools will cease functioning out

These nurses are attending class in the new educational building of the Hartford Hospital, Hartford, Conn.



Brick and glazed terra cotta and limestone trim were used for the exterior of the new educational building, the design of which harmonizes with the other buildings of the hospital group. The tiled swimming pool, pictured below, is on the ground floor.



of deference to the much discussed five-year plan, then it is the duty of our schools to provide the best facilities possible for this work. This brings us to the problem of teaching units designed and built expressly for this purpose.

It is hardly to be expected that a large percentage of the hospitals maintaining training schools are in a financial position to warrant such an undertaking any more than Hartford Hospital is, for that matter, but there are ways by which these problems can always be solved. In 1921, Hartford Hospital entered upon a building program with a view to rounding out the requirements of the organization. Since that date we have added twelve buildings to our group, ten of which have been gifts. It is a brief discussion of the last of these buildings that occupies us for the moment. This is the D. Newton Barney Educational Building.

In the chemical laboratory on the ground floor the nurses carry out the various experiments that are necessary in their work.

Providing for Future Needs

At Christmas, 1930, Mr. Barney, after familiarizing himself with the needs of such a building, announced his willingness to finance its construction and to place a certain amount of endowment in the hands of the hospital, the income from which is to be used in the maintenance and upkeep of the building. Plans and specifications were drawn and, as usually is the case, many features had to be altered and omitted in order to bring the cost of construction within the specified amount set aside for this purpose. Construction was begun in May, 1931, and the building was officially dedicated and opened on February 10, 1932.

Institutions that make any pretense to progress are likely to require more rather than fewer accommodations as the years go by. Consequently, the roof of this building was poured and constructed as a floor and the bearing walls were made strong enough to take additional stories if at any time in the future these should be indicated. The main stairways extend to the roof. The building is fire resistive throughout, being constructed of brick and glazed terra cotta with Indiana limestone trim.

The top floor consists of the following: one room where the probationers are taught how to make and change beds, and to prepare and give treatments; an adjoining room where the lectures are

given; the dietetic laboratory, and one additional lecture room which will accommodate a class of twenty-eight.

On the main floor are the offices of the instructors in the school, three in number, accommodations for the nurses' wraps and umbrellas, the reference library, one classroom with a seating capacity of 160 and the gymnasium. The classroom is separated from the gymnasium by curtains made of the most nearly soundproof material that could be found. These curtains may be drawn aside in such a way as to convert this classroom and the gymnasium into an amphitheater with a seating capacity of 700. The classroom can also be screened so that an audience of 160 persons may observe contests and performances held in the gymnasium.

On the ground floor are the chemical laboratory, the machinery room, the swimming pool, a room for drying and storing the nurses' bathing suits, the locker room with 300 individual lockers, a room containing twenty dressing booths, a towel room, a small room containing three large electric hair drying machines and ten showers. The side walls and partitions of the entire ground floor are of glazed terra cotta. The ceiling over the swimming pool is soundproofed, which eliminates the usual disturbing noises connected with all swimming pools not so equipped.

Twelfth Study on Costs of Medical Care Is Published

Medical care costs $36.09 per capita annually in "an up-to-date rural community," which has been surveyed by the Committee on the Costs of Medical Care, according to the results of the study made public at the Department of the Interior.

This, the twelfth of a series of studies made by the committee, contains significant data on medical care in San Joaquin County, California. It is part of the committee's five-year program of research into the problem of "the delivery of adequate, scientific medical service to all persons, rich and poor, at a cost which can reasonably be met by them."

The per capita cost of $36.09 for medical care in San Joaquin County is divided as follows:

	Per Capita	*Pct. Total*
Physicians	$8.68	.24
Hospitals (including out-patient departments)	8.48	.24
Drug stores	6.75	.19
Dentists	5.76	.16
Nurses	1.82	.05
Other practitioners	1.80	.05
Public health	1.24	.03
Optical firms	1.16	.03
Commercial laboratories	.40	.01
Total	$36.09	100.00

One per cent of the entire population of the county, or 2.3 per cent of all those gainfully employed, were engaged in providing medical care in one form or another.

Of the total of 1,045 individuals who devoted full time to the maintenance of health and the curing of illness in this county of 100,000 individuals, 37 per cent were hospital employes, 14 per cent were private duty nurses, 12 per cent were clerks and assistants to individuals in private practice, 10 per cent were druggists, 8 per cent were physicians in private practice, 6 per cent were dentists, 4 per cent were persons engaged in public health work, and 9 per cent of the total were engaged in laboratories, in optical firms or in other forms of medical care.

According to Dr. Nathan Sinai, member of the research staff who made the survey for the Committee on the Costs of Medical Care, the nurses whom he interviewed expressed considerable dissatisfaction with the economic aspects of their profession.

The average cash income of all nurses is approximately $1,100 a year in addition to board and room while employed. Although the average for graduate nurses is somewhat higher than this figure, the average for practical nurses is scarcely $700.

It was found that two pharmacists in one drug store filled more than 23 per cent of the 126,000 prescriptions compounded by the 51 drug stores during the year of the study. Few of the 98 full-time pharmacists in the county devote the major portion of their time to the practice of their profession.

A great amount of unnecessary duplication in stock was discovered at many of the stores. The inventory of one store showed 148 brands of liver pills, and in another store 33 brands of mouth antiseptics and 65 varieties of tooth paste.

An analysis of prescriptions compounded in 1909, 1919, and 1929 brings out three marked trends. The number of ingredients in prescriptions is decreasing; proprietary remedies are used more frequently, and the price of prescriptions has nearly doubled.

Of a total of $625,911 spent for medical care in drug stores, the following are the percentages:

Patent medicines, .37; prescriptions, .21; home remedies, .20; rubber goods and other medical supplies, .22.

In addition to the sales made at drug stores, it is estimated that the twelve Chinese herb stores during the year sold $50,000 worth of herbs.

Should Hospitals Lower Their Rates to Meet Present Conditions?

By W. HAMILTON CRAWFORD
Superintendent, South Mississippi Infirmary, Hattiesburg, Miss.

"TOMATOES are cheaper, potatoes are cheaper, now's the time to fall in love," says Eddie Cantor.

As yet the poor hospital superintendent sees no comedy in the present situation. Frankly, it is amusing to learn of a few new procedures that have been introduced into the hospital field for the explicit purpose of obtaining additional funds. On this very trip I visited George Sheats at his palatial and massive Baptist Memorial Hospital here in Memphis. Promptly upon entering the front portals of the hospital, my attention was drawn to an exquisite window blind. The question, of course, immediately arose as to how it was possible to buy so beautiful a blind at a time such as the present (it was brand new). Soon the superintendent appeared, and I quite naturally asked the whys and wherefores. "Oh, it was bought by our guests." I asked if he literally meant this. "Why, certainly. You see I placed a box on the business office counter and marked it 'For the Blind.' "

One Way of Cutting Expenses

Several weeks past while I was in a conference with the superintendent of a 100-bed denominational institution, he rather boastfully pointed to his success in reducing materially the institution's operating expenses. My observation provided these facts: Periodic prayer meetings were held in which this director was able to produce a great feeling of spiritual responsibility in his employees. Shortly before the adjournment of the meeting the subject of hospital finances would be lightly dealt with, with the end result that Negroes who were making eight and ten dollars a week are now making less than two. The floor supervisors have all been discharged and seniors placed in these positions. The dietitian's services were dispensed with and a raw recruit from the farm was placed in charge of this important department; the menus, however, are arranged by the telephone operator. The surgical supervisor was likewise dismissed, and a young woman from the graduating class selected to take her place at a remuneration of maintenance only. The superintendent of nurses is paid the meager sum of $75 a month, and the superintendent deducted from his pay envelope $100 a month.

So this is one way of cutting operating expenses. There must exist in that institution a marvelous spirit among the personnel or else only a mere possibility of any one of those unfortunates obtaining employment elsewhere. Indeed, I am not in sympathy with pauperizing any organization. With all of this, do you think that their rates reflect any partial benefit? No. You must immediately admit that therein lies a lack of economic balance.

Were it possible to present our outstanding hospital executives in an intelligence parade on this subject, I am certain that even then you would not become imbued with the idea of finding any miraculous panacea.

A general period of depression drags into its net every conceivable business and profession. These economic curdling battles coagulate and freeze those in the weaker brackets while at the same time they definitely benefit some individuals and organizations. Would it not be advantageous, therefore, for our American hospitals to reap constructively? This is an invitation, an opportunity, a challenge and even a demand that you must heed.

The Need for "a Balanced Budget"

The automobile parts jobber is operating his business to make a profit; so is the wholesale grocer; so are the railroads. This, however, is not true of hospitals in most instances. They were not intended to make a profit; consequently, when no profit is shown there is no disappointment. The American cry of the day, "a balanced budget," is essentially a desirable slogan for the hospital superintendent. In all commercial ventures where intelligent executive control exists, the fundamentals of producing business are determined prior to the pricing of merchandise or service. These fundamentals may be listed as original commodity purchase price, salaries, rent, credit losses, insurance, taxes, light, heat and water.

Under such influences, when branches or new

ventures are considered, a careful survey of the field of prospects is made and thoughtful consideration is given to margins allowed in similar businesses operating in the same territory. The occasion for an additional organization, the capital required and the possible return to be expected are all carefully scrutinized. The final decision is then made, resulting, of course, in spite of precautions, in a certain number of mortalities. Nevertheless, saneness prevailed at the offset, and if success was not attained it was due to the lack of ability on the part of the group or individual to interpret properly the audit sheet or else it was due to the development of conditions over which they held no control.

Hospitals Are Businesses

We are told, "In time of peace prepare for war." Its economic parody is, "In time of depression prepare for business." In the general business realm, the small merchant and huge corporation alike have by necessity brought about a new operating order in their respective structures. Vagueness has been removed from the brain and has been supplanted by foresight and keen conceptions of conditions at large. New economies have been introduced, more exacting programs of efficiency prevail, the periodic comparative cost statement is given detailed consideration. Again do you exclaim, "Why, hospitals are different!" Fundamentally, there is no marked difference. We simply are distributing a service from producer to consumer, be it free or for sale. This is not void of cost in the making.

Community Survey Should Precede Building

May I emphasize the importance of a more enlightened daily comparative cost statement of your institution to include depreciation, bond interest and even the bond principal maturities. During the inevitable lull in your activities you should contact an unusual hospital executive, an alert, well posted certified public accountant or the American Hospital Association, for a suggested cost system which is adequate and yet not too elaborate for immediate installation.

A careful community survey unquestionably should always precede the founding of a new hospital. What is the population of territory to be served? The present morbidity and mortality rate? The number of beds per thousand persons now available and their relationship to the generally

TOURO INFIRMARY, NEW ORLEANS

Private—373 Beds

	1930	*1931*		
Largest number in hospital any one day	303	264	Minus	39
Smallest number in hospital any one day	160	163	Plus	3
Total admissions	9,475	8,549	Minus	926
Total patient days	89,833	78,752	Minus	11,081
Patient per diem cost	$3.897	$3.852	Minus	$0.045
Number of public case days	35,063	30,331	Minus	4,732

Receipts

	1930	*1931*		
Operating revenue	$466,045.27	$405,421.81	Minus	$60,623.46
Allowances to patients	14,992.74	12,414.55	Minus	2,578.19
	451,052.53	393,007.26	Minus	58,045.27
Business revenue	10,419.70	10,128.48	Minus	291.22
Gross operating revenue	$461,472.23	$403,135.74	Minus	58,336.49

Expenses

Operating expenditures	$511,518.34	$447,648.46	Minus	$63,869.88
Operating deficit	50,046.11	44,512.72	Minus	5,533.39
Fixed charges (bond interest)	20,882.48	20,882.48	No change	
Gross operating deficit	70,928.59	65,395.20	Minus	5,533.39
Nonoperating income (subsidy from city, Community Chest, etc.)	$ 55,969.50	$ 51,607.00	Minus	$4,362.50
Net loss	14,959.09	13,788.20	Minus	1,170.89
Accounts charged off	10,884.18	4,755.90	Minus	6,128.28
	$ 25,843.27	$ 18,544.10	Minus	7,299.17

EMERSON HOSPITAL, CONCORD, MASS.

Private—38 Beds

	1930	1931		
Per capita cost (cost per patient day)	$5.31	$5.77	Plus	$0.46
Largest number in hospital any one day	44	36	Minus	8
Smallest number in hospital any one day	12	6	Minus	6
Total admissions	932	709	Minus	223
Total patient days	8,871	7,287	Minus	1,584
Daily cost of operating hospital	$103.04	$115.22	Minus	$12.18
(These figures do not include depreciation)				

Receipts

	1930	1931		
Private rooms	$14,523.03	$13,008.86	Minus	$1,514.17
Wards	14,183.81	11,143.26	Minus	3,040.55
Operating room	2,699.50	1,790.34	Minus	909.16
X-ray department	3,422.00	2,953.50	Minus	468.50
Delivery room	1,678.00	1,547.67	Minus	130.33
Special nurses' board	1,261.52	1,246.60	Minus	14.92
Medical supplies	463.13	480.12	Plus	16.99
Anesthesia	1,577.50	1,050.08	Minus	517.42
Pathological	487.50	310.50	Minus	177.00
Laboratory fees	1,863.00	1,666.33	Minus	196.67
Misc. and nonoperating receipts	686.27	411.36	Minus	274.91
Loss	4,620.00	6,642.87	Plus	2,022.87
	$47,465.26	$42,251.49	Minus	5,203.77

Expenses

Salaries	$19,320.28	$19,093.18	Minus	$ 227.10
Supplies	5,498.91	3,997.54	Minus	1,501.37
Provisions	10,074.49	7,502.86	Minus	2,571.63
Laundry	5,626.99	4,651.16	Minus	975.83
H. L. and water and telephone	3,700.10	4,025.46	Plus	325.36
Insurance	356.29	335.45	Minus	20.84
Maintenance of plant	866.37	925.53	Plus	59.16
Laboratory fees	1,434.00	1,317.99	Minus	116.01
Misc. and nonoperating payments	587.83	402.32	Minus	185.51
	$47,465.26	$42,251.49	Minus	5,213.77

accepted ratio? The existing demand for additional hospital facilities? Can the sponsoring group popularize the new institution or would it display better judgment perhaps to use the available funds for enlarging one of the present institutions? Are the necessary funds to construct, equip and maintain the proposed venture accessible and under intelligent supervision? Fully agreed on these and numerous other factors, we come to the matter of dispensing the service, a tremendous item.

Many Factors Influence Rate Schedule

We often hear the remark, "Oh, that's just an old Spanish custom," and so it seems to be with our hospital rates. At the onset a series of questionnaires are sent out to seek a knowledge of rates elsewhere. On their return, a schedule of rates is adopted. It is ridiculous to believe that because the Tacoma General Hospital offers ward rates for $2 that your institution must do likewise. The same thing is true with the dozen of other services such as anesthesia, the operating room, the laboratory fees and so on. To me it would seem that the intelligent procedure would be to tabulate those factors of cost production in your own institution and gauge your rates accordingly?

It is very true that you must consider the competition in the field; consequently if after having made your computation you find that it is not practical to place your charges on a like basis with others in the field, recognize the necessity for further investigation. Visit other superintendents. Due to the peculiarity of our profession, their books will be thrown wide open for your examination and a general detailed explanation will be available for the asking. There is such a tremen-

dous number of causes for variations, due primarily to investments, types of services offered, hospital municipal relationships, institutional objectives, factors included in the cost picture, the ability of the administration and others, that it is useless to pare daily costs until you have thoroughly analyzed the situation. Incidentally, you would display excellent judgment to redetermine the justification for your hospital's rates.

The simple application of economic balance must be instituted; else the life blood will be sapped from any organization. An article or service sold below the cost of production may pass unnoticed, but the continuation of such practices, unless the institutions are subsidized will bankrupt hospitals, manufacturers and hotels. The inference is that when the ward case is paying $3 a day when the actual cost of that service is $4.50, there is a $1.50 loss to be absorbed through some channel or else to appear as a deficit. In most instances, the moderately wealthy group and the "well ables" are carrying the load. Of course, there is an exception: when an organized charity group, an individual or a municipality assists in balancing the budget.

The trend of the business cycle reproduced in graph form expresses itself in geographical terms, hills and valleys. In accordance with the old law of supply and demand, the commodity market goes up and down. The downs are only in proportion to the ups. A span of fifteen years has seen hospital production costs increase 135 per cent. The increased charge to the public has only been 65 per cent. It would seem, therefore, that only when general production costs of hospitals can decrease from the 135 per cent increase level to the 65 per cent level will there be a proper balance. The statement was recently advanced by a prominent personage on the U. S. Board of Trade that this economic disturbance, worldwide, is due to a lack of proper relationship between production costs and sales prices. His remark certainly describes our hospital situation.

Misleading Misconceptions

Hospital Day was inaugurated to break down those misconceptions held by the public toward our hospitals. A few of the causes of society's criticism of the hospitals is attributable to the demand for reduced rates. Check them over:

1. Misinformed by unqualified writers and speakers, coupled with insufficient explanations by some superintendents.

2. Accepting ward rates as the actual cost of producing service, followed by the opinion that other bed rate differences represent profit.

3. The failure to consider other factors of cost aside from room furnishings and nurses.

4. Selection of rooms beyond the patients' means.

5. Unfair requirements made of hospitals that are never made of other businesses.

6. Failure to separate hospital charges from special nurses', doctors' and special anesthesia fees.

In the main, whether or not a reduction in hospital rates is feasible, this subject must be narrowed to the individual institution. I offer for your consideration the superintendents' comparative operating statement of a small New England hospital and that of a larger Southern hospital. Allow me to prejudice you at the offset. Appreciating the full need for maintaining a minimum standard at all times, I believe it wholly impossible for these two institutions to reduce their rates. Should your auditor's panorama display a financial picture such as that offered here, or in any way comparable, you too will agree that it cannot be done.

A Helpful Program Is Suggested

The tabulation of each hospital superintendent's wishes with regard to hospital charges emphatically would reveal a unanimous desire to lessen the present schedule. May I suggest a program for society at large?

1. Hospitals to be protected at least to same degree that hotels are protected by the hotel fraud bill.

2. Fair and just hospitalization allowance in all workmen compensation acts.

3. Fairer equalization of the charity load, more intelligently distributed among municipalities, state governments and society at large.

4. Legislation requiring all automobile owners to carry liability insurance, thereby reducing tremendous financial losses to hospitals through this channel.

5. Taking an enormous tax burden from the public through utilizing thousands of civilian hospital beds for the hospitalization of veterans.

6. Keeping hospital boards from investing fabulous sums in construction and unnecessary equipment.

7. A periodic survey made by a competent consultant.

In the meantime I shall believe that not until you can present your note to a banker not of your acquaintance and promptly have a loan executed, not until you can do something about the weather, should your hospital reduce rates to meet present economic conditions. Until then, I shall wonder why you do not raise your rates to the present economic level.[1]

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[1]Read at the joint meeting of the hospital associations of Arkansas, Kentucky and Tennessee, Memphis, Tenn., April 18 and 19.

Hospitalizing New Jersey's Poor and the Payment Problem

By ALLERTON DELANO HITCH
Treasurer, New Jersey Orthopedic Hospital and Dispensary, Orange, N. J.

ONE of the annoying problems of the hospital executive in New Jersey is the indigent patient who has no settlement in the municipality in which he is a resident.

There are three classes of these indigent patients: those having settlement in another community in New Jersey; those having settlement in a community outside of New Jersey; those whose settlement in some other community has expired and they have not yet lived long enough at their present address to obtain a settlement in that community.

To a layman the New Jersey poor laws seem clearly to make it the duty of the overseer of the poor, where the patient is then living, to give relief, either temporary or permanent, but it is quite another thing to find an overseer of the poor who will take this view. Almost all of them either refuse to consider the case or pass the responsibility to the officials of the municipality wherein the patient has settlement.

The number of such cases coming to the hospitals has largely increased in the last two years because of migration due to unemployment; nor is the evil likely to abate for some time.

In the case of those having settlement elsewhere in the state and those having settlement in some other state the *modus operandi* is the same: Application should be made to the overseer of the poor where the patient is then living, and that official should reimburse the hospital and then in turn endeavor to obtain reimbursement from the poor department of the municipality wherein the patient has settlement.

Complications of the New Jersey Laws

The fact that in New Jersey it takes five years for a person to obtain and lose settlement complicates matters. A further complication is that the 1924 poor laws provide that when such relief has been provided for a person whose settlement is without the state, the overseer shall then apply immediately for the family's removal back to the place of settlement. New Jersey overseers of the poor are inclined to hesitate in approaching overseers in other municipalities for reimbursement. Many also object to initiating proceedings for the removal of dependent families to their places of legal residence.

We had an indigent patient with settlement in New York City, who had been living in one of the Oranges for ten months. We applied to the overseer of the poor there and he eventually collected from New York City and paid us. We were reimbursed but we should not have been if New York City had not paid the local overseer of the poor first. We contended that the hospital should be paid by the local overseer regardless of whether he obtained reimbursement or not, especially in emergency cases. As we could not induce any local overseers to take this view, we referred the matter to the council of social agencies which in turn asked Judge Edward L. Davis of Orange for a formal opinion as to the obligations, duties and responsibilities of public officials, more especially overseers of the poor working under the New Jersey poor laws, with regard to the types of indigent persons referred to in this paper.

A Legal Opinion

Judge Davis' opinion follows.

"I have made a careful investigation of the statutes with the following result:

"Apparently the first duty of an overseer of the poor is to render relief whether the same be temporary or permanent. After he has done this, the question of primary responsibility for the relief afforded may then be taken up by him. This is reiterated again and again in various sections of the revision of 1924.

"Section 50 provides that where no settlement of such person exists in the municipality or county in which relief is sought or necessary, 'all such persons shall be temporarily provided for and shall be removed by such procedure as may be lawful and necessary.'

"Section 52 provides that 'when temporary relief is required by a poor person in any municipality in which he is a resident and inhabitant whose place of settlement is in some other county in this

state, the overseer shall provide and render temporary relief.'

"Section 53 provides that 'where temporary relief is required by a poor person . . . and it shall be ascertained that his place of settlement is outside this state, the overseer shall provide relief and immediately make such application, with the aid of the county adjuster, as may be necessary and otherwise lawful for his removal. . . .'

"It is quite apparent that the revision attempts to and does provide for every possible case which would be as follows: cases in which a legal settlement exists in the city or county; cases in which the legal settlement is in some other municipality or county of the state of New Jersey; cases in which the legal settlement was in some other state.

"In every such case, the duty of the overseer of the poor is first to provide temporary relief and after that has been done, to endeavor to recover for such relief from the place of settlement of such person to whom relief has been provided. This seems so clear to me as to be beyond dispute."

In a number of cases this opinion has been cited to overseers of the poor who reply either that the matter has been referred to their city counsel, which ends the case so far as we ever hear, or else that the city counsel disagrees with Judge Davis.

The cost to the hospitals for indigent patients runs into hundreds of thousands of dollars every year and is rapidly approaching the point where hospitals must obtain relief or shut their doors to such indigent patients.

The Dangers of Imperfections in Clinical Thermometers

"Fever temperatures have been with us from the earliest times, but there existed no reliable means of measuring them until the development of the clinical thermometer," writes Friend Lee Mickle, director, Bureau of Laboratories, Connecticut Department of Health, in the *United States Daily*. "Early in the eighteenth century Martine wrote an essay on clinical thermometry. About 1800 Currie used cold baths in typhoid fever and checked results with a clinical thermometer.

"Wunderlich, in 1815, wrote the first scientific book on fever temperatures. Clinical thermometers began to make their appearance in English hospitals and soon after 1866 came into general use. Most physicians in the Civil War did not see a clinical thermometer although Billings used them in caring for the wounded after the siege of Richmond.

"He would not have recognized one. They were about 10 inches long, so large it took at least five minutes for them to register the axillary temperature they were designed to indicate and so clumsy they were carried under the arm as one might carry a gun. They did not hold their highest reading but were read while in position in the patient's armpit. The reduction in size, or the invention of the pocket thermometer, was due to Sir Clifford Allbutt in 1868.

"Clinical thermometers are made from strips of glass tubing. With a gas flame a glass bulb is blown and sealed to the thermometer and a blister raised inside the stem. The tube is then filled with mercury, the top of the stem sealed and the blister collapsed so the thermometer will hold its reading. To engrave it, the thermometer is covered with wax and passed through scaling machines that cut through the wax where the letters, figures or graduation marks should appear. The wax covered thermometer is then dipped into acid to etch the glass where the wax has been cut away. The etchings are later filled with colored pigment. The thermometer is ready for testing.

"Faulty clinical thermometers can cause serious errors in the diagnosis or treatment of disease. In an article on this subject a physician recently stated that the unfortunate results that occasionally occur in the treatment of disease are due to no single factor so much as to the faulty taking and recording of temperatures by careless individuals.

"One should be certain that the clinical thermometer registers accurately, for the physician places great reliance on the temperature reading taken with it. It should be handled carefully because it is a very delicate instrument. It may not record accurately after abuse."

Regulating the Use of the Staff as Blood Donors

How the University of Chicago Clinics regulates the use of hospital personnel and staff as blood donors is set forth here briefly:

1. It is not the intent of the administration of the clinics to have members of the staff give blood for blood transfusions.

2. Members of the staff are, however, free to be blood donors in case of a real emergency and when no one else is available.

3. When such blood transfusions are given they will be paid for on the regular schedule—for ward and free patients $7 per 100 c.c., for private patients $10 per 100 c.c.

Innovations That Feature a New Hospital Building

By JANET PETERKIN
Assistant Editor, THE MODERN HOSPITAL

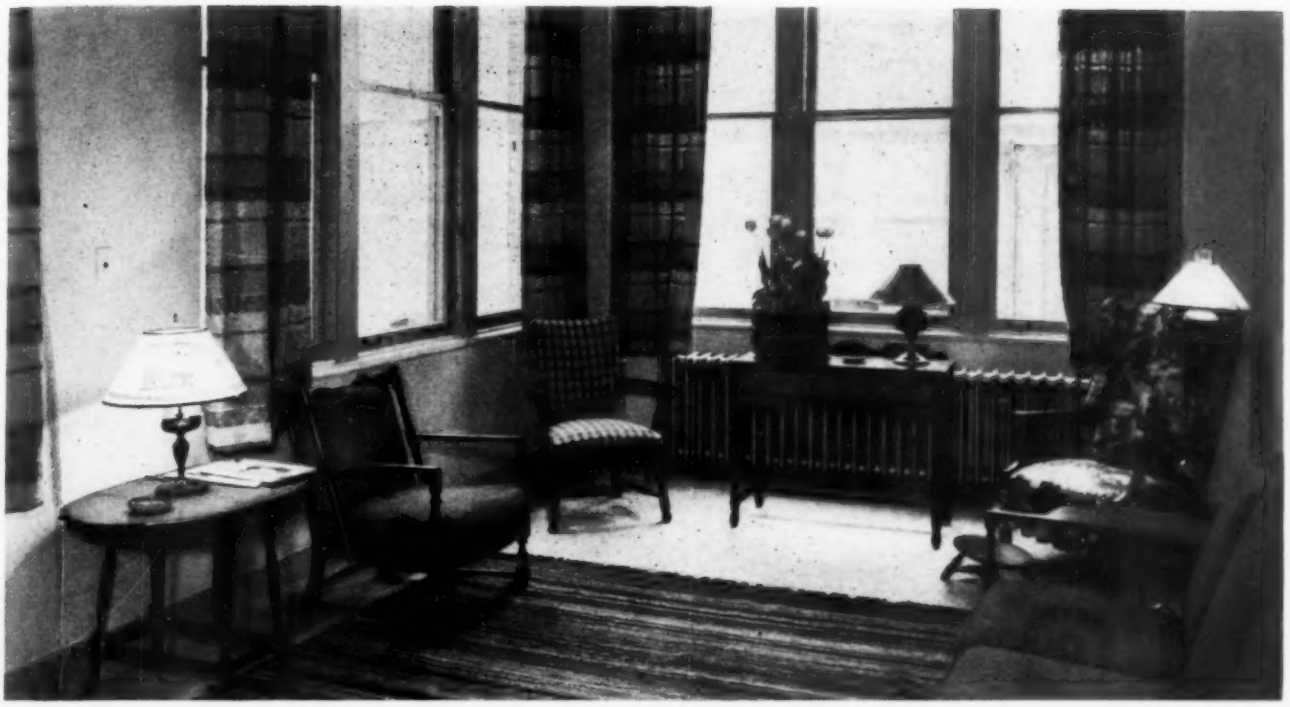
TO the Milwaukee Hospital, Milwaukee, goes the credit for having introduced to the hospital field an entirely new idea in lobbies —the lobby with a mezzanine, a type for many years popular in hotels but one that has not so far, it is believed, been met with in hospitals. Many merits suggest themselves as accruing from this arrangement.

As the visitor enters the hospital he finds himself in a handsome and spacious lobby, impressive in its lofty proportions and in its dignified simplicity of design. Furniture and equipment are in keeping with the purpose of the room. Walls and pillars are of beautifully marked walnut and the lighting fixtures are so disposed as to cast a soft light into all parts of the lobby and to avoid glare.

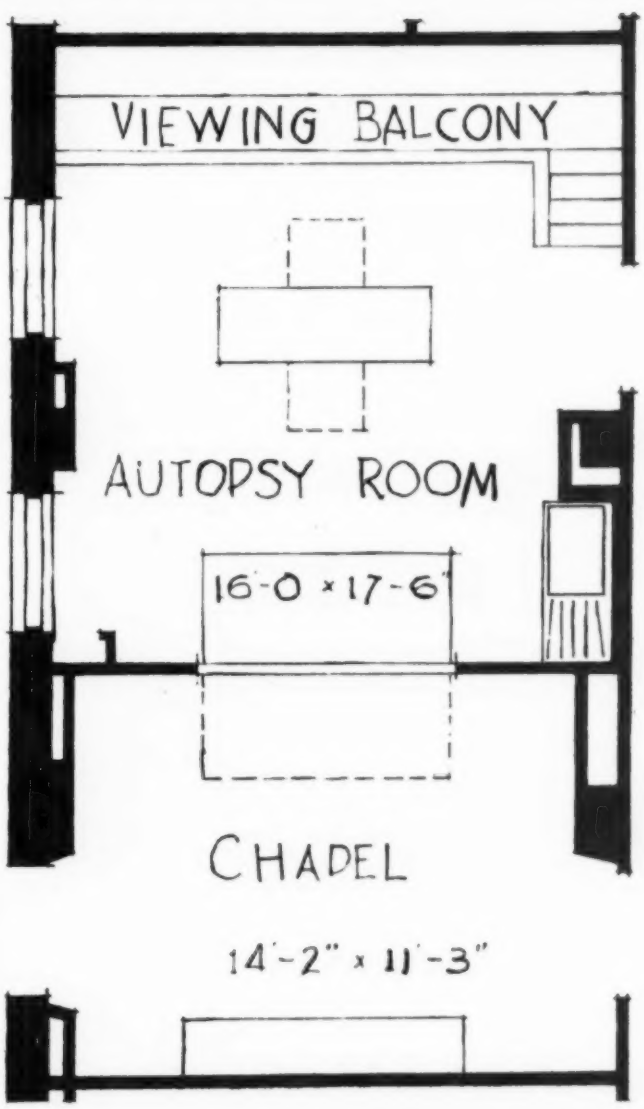
Arranged around the walls under the balcony are comfortable davenports and easy chairs where the visitors and patients' relatives may wait with a certain degree of privacy. Nothing could be further removed from the traditional hospital lobby, so austere and so aggressively "clean."

The mezzanine floor takes the place of a sun parlor for convalescent patients. It has many windows through which the sun streams, and excellent taste has governed the choice of the furnishings. Handsome draperies of printed linen are in tints that harmonize pleasingly with the green and tan color scheme that dominates the entire building. The floor is of rubber of a green and tan tile pattern and has a terrazzo border. The davenports and easy chairs are richly upholstered in different

Beautiful oak tile floors are a feature of the private rooms of the Milwaukee Hospital. Giving the effect of parquetry of a rich golden color, these floors are both noiseless and resilient. Patients can register in private in the admission room, pictured below, which opens off the main lobby.



On every floor convalescents can enjoy the sunshine in gayly furnished sun rooms like the one pictured above. Opening off these rooms are porches where bedding can be aired. Much thought was devoted to planning autopsy facilities. The plan at the right illustrates the layout of this department, which contributes to the dignity with which autopsies are conducted.

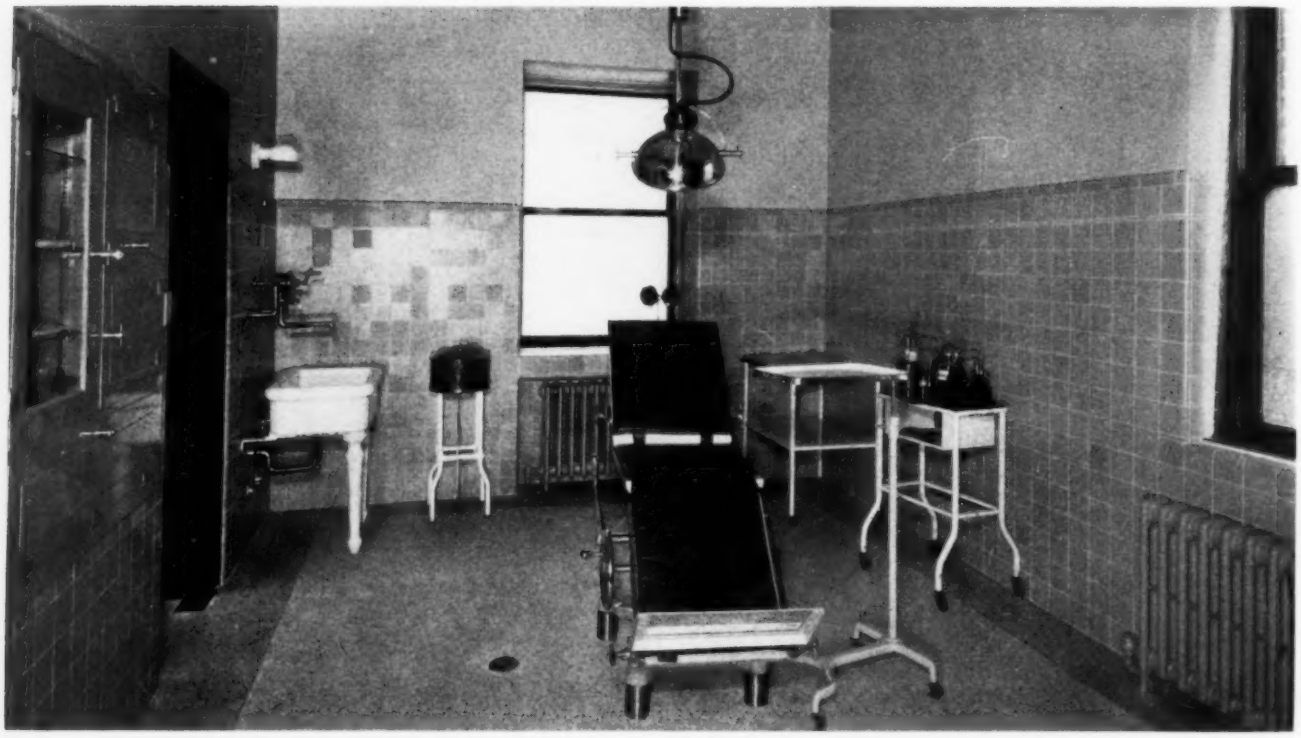


colors and designs that blend into the general picture. The accompanying illustration shows the unusually attractive coffee tables and other pieces that combine to make this mezzanine a delightful place for anybody, sick or well, to rest. A stained glass window, representing the Good Samaritan, sheds a rosy glow over the whole and is a reminder of the hospital's fundamental purpose. Undoubtedly, patients who are a little weary of being withdrawn from life in a hospital room will find it a welcome change to recline in an easy chair in a sunny spot and view from a safe distance the happenings of the hospital lobby.

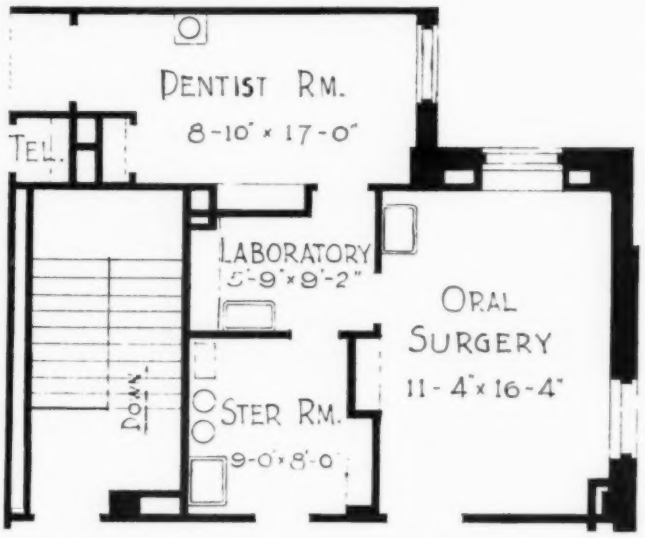
Histories Are Taken in Private

Opening off the lobby to the right of the entrance and adjoining the information desk is the admission room. Here, in private, patients are registered, their histories are taken and all necessary papers are filled out. This arrangement and others evidence that in the planning of this building kindly consideration has been given to the patients' comfort and sensibilities.

Parallel to this room and on the left of the entrance is another comfortably furnished room



The dental and oral surgery unit is unusually well laid out and complete. The oral surgery, illustrated above, has an operating table and a built-in cabinet and built-in viewing box. The interesting arrangement of this unit is shown in the floor plan at the right.



which serves a happy purpose. It is a private parlor, reserved largely for the use of patients' relatives and friends who may wish to talk privately with the doctor or who may be in distress of mind and will welcome some spot where they can regain composure before leaving the hospital. This room is also occasionally used for board meetings or business conferences.

The idea for the mezzanine lobby originated with Herman L. Fritschel, superintendent of the hospital for thirty years, and was admirably carried out by the architects, Clas and Clas, Milwaukee.

The private rooms of this hospital feature a new departure in the beautiful oak tile floors. These give the effect of old-time parquetry. They are in a rich golden color which at once gives warmth to the room and they add the decorative value of a design. The wood for these floors is chemically treated so as to reduce the tendency toward shrinkage or expansion by making the wood more moisture resistant and also to protect against corrosion and to give permanance to the floor. The blocks are laid in a sound deadening plastic cement. Noiselessness and comfort underfoot are therefore attributes of this type of floor. It is quite a contrast to the old type of purely utility flooring and is said to be easy to maintain and to cost no more than terrazzo.

The Dental Unit Is Noteworthy

One interesting constructional feature of this hospital is the unusually complete and well laid out dental and oral surgery unit. It includes four rooms—the dental surgery operating room with a dental chair and a built-in metal cabinet for all types of instruments; the oral surgery with an operating table and a built-in cabinet and a built-in viewing box; a laboratory opening off the surgery for the construction of orthopedic appliances for jaw fractures and for other purposes, and a sterilizing room. A staff oral surgeon does every type

of dental and oral surgery as well as facial plastic work in this unit. This suite is used also for his private ambulatory patients. The accompanying floor plan section shows the arrangement of this department.

In the orthopedic or plaster room where the latest type of fluoroscopic table is to be installed a clever arrangement has been introduced for turning the room into a dark room. Specially designed wooden shutters made in four sections are placed below the window. They are pulled up one at a time and are so arranged that they overlap and make it impossible for a ray of light to leak through, thus making the room 100 per cent lightproof, a result that can never be achieved with ordinary shutters. The eye operating room is equipped with the same kind of shutters. A small room for splints opens off the orthopedic room. The walls of these rooms have pale green tile wainscots, near the top of which a narrow band of dark green tile is effectively placed, and the walls above are tan. Variations of this color arrangement are found throughout the institution.

Self-regulating built-in radiators are used in all parts of the house. These control the temperature, keeping it at any desired degree. They are usually placed under the windows, which saves space and does away with the rather unsightly coils of the older type of radiator.

In the operating rooms, of which there are seven, a built-in humidifier is regulated to give the desired humidity to the room. This helps to prevent accidents due to sparks resulting from the discharge of static electricity and makes less necessary the electrical grounding of the floor of the operating room. Every operating room has a built-in cabinet with x-ray viewing box, a suction pump and electric connections.

The mezzanine floor, with its many windows and tasteful furnishings, is used as a sun parlor for convalescent patients.

Caring for ward patients' belongings, always a thorny problem, has been solved in this hospital by placing in every ward a built-in steel locker for the use of each patient. Another convenience found in every ward is a washbowl with running hot and cold water. If the walls are green the bowl is tan, and vice versa.

The autopsy room, so often relegated to some dismal corner in the basement, has in this case been placed on the first floor and thought has been

expended in planning it. The room is in two sections, separated by a heavy curtain. The smaller room is the morgue. This has painted walls, with a striped design in shades of tan and an artistic border. The table for the body is on wheels and is draped as in a chapel. When the autopsy is about to be performed the curtain is drawn aside and the table bearing the body is wheeled to the side of the autopsy table. The autopsy room has a viewing gallery which seats ten persons.

Sound absorbent material has been liberally applied in the corridors, kitchens, business offices and other spots from which noise emanates. The kind of material used is an acoustical tile made of a spongy mineral substance. It may be cleaned with wall paper cleaner.

The steel frame of the new building at the Milwaukee Hospital was electrically welded and the erection of the structure proceeded in quietness. This method of building costs no more than steel riveting and the nerve racking noise that accompanies the latter process was mercifully spared the patients in the older building.

This new section of the hospital takes the place of the original hospital built fifty years ago. With the sections built in recent years it provides modern equipment and accommodations for 275 patients.

Why Hospitals Object to Giving Up Their Training Schools

A nursing school is the source of considerable financial profit to most hospitals. To give up their training schools would mean the yearly loss of fairly large sums of money.

So declare 82 per cent of 208 hospitals, the nursing schools of which have taken part in the cost study of the Committee on the Grading of Nursing Schools. Only 18 per cent believe that they would save money by giving up the schools and substituting graduate nursing care for their patients.

This first cost study of the grading committee rather than producing authoritative results shows the need of further study, Dr. May Ayres Burgess, director of the committee, declares in presenting the results in the April number of the *American Journal of Nursing*. She believes, however, that further studies will not change greatly the relative proportions of schools that would lose or gain by discontinuing their schools.

One-fourth of the schools reported either that they would save money by giving up the schools or would lose less than $2,500. Another fourth estimated that discontinuance of their training schools would bring an annual loss of $23,350 or more. The middle group estimated that it would lose $10,500 yearly by such a move.

Although it has an average of fifty-five patients, one hospital estimated that by closing its nursing school it would save $209 a patient each year. At the other extreme was the estimate of a hospital that it would lose $525 per patient per year.

To place hospitals with large schools and with small schools on the same basis, the hospital was asked how it would replace every ten students. Replacement figures received showed wide variation in the number of graduate nurses and maids thought necessary to supplant the students.

Canadian Survey Findings Challenged

Findings of the grading committee challenge the results of the study of nursing education in Canada made by Dr. G. N. Weir. Dr. Weir's figures seemed to show that nearly all hospitals would save money by giving up their training schools and that the larger the hospital was the more money it would save.

Several of the largest and most respected nursing schools in the United States made cost studies for the grading committee. Their studies were made with great care and in some cases accounting experts were called in from the outside. Yet in every case the larger hospitals report that they would lose a large sum by giving up their schools.

"To any thoughtful educator," says Doctor Burgess, "the proposition that a professional school can be a source of considerable financial profit to those who control it seems incredible. All educators would normally take it for granted that schools of nursing which are well run must necessarily be extremely costly. That in nursing the opposite is true is one of those unfortunate facts that only the person of long experience in the field can accept."

Janet M. Geister, R.N., director at headquarters, American Nurses' Association, sees in the situation a challenge to educators, hospital administrators and the public.

"It isn't enough that the nursing profession takes cognizance of these facts," Miss Geister declares. "John R. Public must too. Nursing care is recognized commonly as an essential in the treatment and prevention of disease and in the promotion of health. When Mr. Public finds his child ill and the doctors diagnose it pneumonia, Mr. Public cries, 'I want the best nurse I can get.' In school Mr. Public had ensured for his son a standard quality of teaching through tax supported or privately endowed universities and normal schools He was pretty sure of his doctors. But he has never raised a finger to help obtain aid for nursing schools or to ensure himself good nursing care."

Assuring a Supply of Pure Milk for Patients and Personnel

By JAMES A. TOBEY, Dr.P.H.
New York City

A department devoted to the discussion of problems confronting both the dietitian and the administrator, conducted by Anna E. Boller, Central Free Dispensary at Rush Medical College, Chicago

[The importance of milk in the diet makes it imperative that a satisfactory supply be available. Therefore, Doctor Tobey's review of the necessary steps in obtaining this will be appreciated, especially by those in small communities, because of the stress he has laid upon such a supply. — Editor.]

NO COMMODITY is more important in the proper conduct of a hospital than is the milk supply. Not only is pure milk necessary in the daily diets of most patients, particularly for preoperative and postoperative cases, convalescents, infants and children, but it has many valuable therapeutic uses. Milk is, furthermore, a staple part of the nutritional régime of the hospital staff.

Every hospital ought, therefore, to have an exceptional milk supply. In many institutions, however, the milk obtained is more or less taken for granted. Its integrity is never investigated and no attention is given to it until some of the less moribund or more obstreperous patients begin to complain vigorously about its quality.

Safety Is a First Consideration

Few hospitals are so fortunate as to possess dairies of their own and some of those having such dairies are less fortunate than might be expected. Most hospitals obtain their milk supplies from commercial distributors, a system which may or may not be advantageous. In the larger cities, market milk supplies are generally above reproach, and some are most excellent, but clean and safe milk is not always obtained in the smaller towns where many hospitals are located.

Although pure milk is the most nearly perfect of all foods, it is also a good food for bacteria. Great care must be taken during the production and transportation of milk to prevent contamination with dangerous micro-organisms. The milk must be clean milk and then, as an added factor of safety, it must be pasteurized.

Why Precautions Are Necessary

Unless a high grade certified milk is available, every hospital dietitian should insist upon having only properly pasteurized milk in her department. In the pasteurization process every particle of the milk is rapidly heated to from 143° to 145° F. and held at that temperature for thirty minutes, after which it is quickly cooled to 50° F. or less and bottled, preferably by machinery, in sterile bottles. This heating operates to destroy about 90 per cent of the bacteria in the milk, including any pathogens that might be present.

The only grade of raw milk suitable for hospital use is that known as certified, which is produced under the careful supervision of medical milk commissions appointed by county medical societies. This milk comes only from tuberculin tested cattle and is also free from contagious abortion. It must not contain more than 10,000 bacteria per cubic centimeter.

The bacteriological, chemical and physical properties of the hospital milk supply should be investigated regularly. If local or state health departments are active in milk control work, as some are, their reports may suffice, but an occasional analysis of the milk by a competent chemist and bacteriologist in the hospital laboratory will be worth while.

No good milk supply should have more than 50,000 bacteria per cubic centimeter in the winter and 100,000 in summer. It should be free from

dirt, as shown by sediment tests, and should have an agreeable flavor and odor. The amount of butter fat will vary with the breed of cattle from which the milk is obtained, but whole milk should, in general, show not less than 3.25 per cent fat.

In some hospitals, bulk milk, delivered in large cans, is used. If the milk is properly pasteurized and placed only in sterile containers, this system may be satisfactory, although it is generally less so than is the use of bottled milk. Bulk milk must always be carefully stirred before it is consumed and great care must be taken to avoid contamination.

Of particular value for use in hospitals as a regular or reserve supply are the concentrated milks, including the condensed, evaporated and powdered milks. These canned products are not only convenient, but they are safe because of the heat treatment used to remove the normal water of the fluid milk. They are also uniform, easily digested, of high nutritive value and inexpensive.

Concentrated Milks Evaluated

The concentrated milk which is now most extensively employed is the evaporated. This product is simply pure whole milk from which about 60 per cent of the water has been extracted by evaporation in a vacuum pan under pressure. This milk is also homogenized by forcing it through fine nozzles, a process which effectually breaks up the fat particles, so that they resemble breast milk in texture. Evaporated milk is likewise sterilized in the can and so is entirely free from bacteria, except for a few innocuous thermophilic organisms.

Condensed milk differs from evaporated in that pure granulated sugar is added after a quick forewarming of the fluid whole milk. This mixture is then concentrated in a vacuum by a method patented three quarters of a century ago. It is not homogenized or sterilized in the can, but its digestibility resembles that of breast milk and the 42 per cent of sugar in the final product inhibits the growth of bacteria.

The dried or powdered milks are made by quite a different method. In the spray process for drying milk, which is the most widely utilized, pure whole milk is first pasteurized and then partially condensed in a vacuum. This milk is then sprayed through a fine nozzle into a large tin lined chamber. As the mist of milk enters at the top of this room, it is met by a current of hot filtered air which instantly removes the remaining moisture. The milk solids fall to the bottom and are promptly removed and canned by a special vacuum process which ensures indefinite keeping qualities of this milk powder.

As in the case of the condensed and evaporated milks, dried milk is more digestible than fluid cow's milk. While it is not sterile, it is uniformly low in bacteria, comparing with certified milk in this regard. Dried skimmed milk is also prepared by this same process, as are such special products as powdered whole and skimmed lactic acid milks, and powdered protein milk. All of these products are widely employed in infant feeding, although a powdered whole milk when reliquefied can be and is used as a substitute for fresh fluid milk.

One of the great advantages of a powdered whole milk is the fact that it can be employed in any concentration desired. It can be added as a powder to ordinary recipes, such as creamed soups, meats or vegetables, and in this manner will increase the caloric value from 25 to 75 per cent, while at the same time it augments the fats, proteins, minerals and vitamins. Although there is some reduction in the content of vitamin C in the process of drying milk, none of the other vitamins is appreciably affected and the nutritional value is consequently unimpaired.

Wherever market milk supplies are of questionable purity or of known impurity, these concentrated milks may be stocked to advantage in the hospital. They are also invaluable for culinary and therapeutic uses even when good fluid milk supplies are available, and a powdered or condensed milk will often come to the rescue in an emergency when other forms of milk are unobtainable.

Physicians and authorities on dietetics are agreed that there is no better food than milk, the one article of the diet that contains nearly all of the elements needed to nourish the human system. Milk must, however, always be clean and safe and every hospital executive should be zealous in his endeavors to guarantee to all in his care a milk supply of unquestionable purity.

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Occupational Disease Clinic Is Opened in Chicago

A weekly clinic for the benefit of those involved in occupational disease hazards has been established at the research hospital of the University of Illinois, Chicago, according to the *Illinois Health Messenger*.

Any person in the state who has been exposed to any occupational disease hazard will be accepted at the clinic for examination, and hospital facilities will be provided for patients who need treatment.

Dental Clinics in the United States —A Story of Their Progress

By MIRIAM SIMONS LEUCK
Committee on Study of Dental Practice, American Dental Association

THE importance of adequate care of the teeth has been increasingly recognized in recent years. At the same time there has been equal appreciation of the fact that these new services demand a seriously high additional expense for the person of average income. It has been suggested that the dental clinic may be one solution. A willingness to test this solution is indicated by the striking increase in the number of clinics in the last decade.

Three important motives have underlain this development of clinics: (1) to provide service for persons who cannot afford the services of a private practitioner; (2) to carry out the public health principle of prevention by caring for children's teeth; (3) in hospitals, to provide dental service as an aid in the treatment of the patient.

In 1922, Dr. Michael M. Davis, at the request of Julius Rosenwald, made a study of the facilities for dental care throughout the country. At this time, the result of inquiries sent to 282 general hospitals including almost all those in the United States of a hundred beds or over, disclosed that 89 out of 144 hospitals replying rendered some type of dental service. Eight years later a survey of all the dental clinics in the United States conducted under the auspices of the Committee on the Study of Dental Practice, American Dental Association,[1] reported 462 dental clinics in hospitals and a total of 1,530 dental clinics in existence.

A Rapid Growth

For the purposes of this study a dental clinic was defined as any institution or organization that renders dental service. Private practice alone was excluded, as were services in hospitals where dental work was confined to oral surgery or in which the dentists on their staffs gave treatment only as private practitioners. The intervention of a third party between dentist and patient and the continuous rather than sporadic offering of dental treatment were made the determining factors of the definition, rather than the age of the patient, his financial condition or any other circumstances.

The rapid growth of dental clinics has not, of course, been confined to hospitals. Four hundred sixty-one of the 1,530 clinics reported were maintained under the auspices of boards of education and boards of health or under their joint control. Dental schools and dental societies maintained 46 clinics, while dental schools and dental societies in cooperation with other organizations carried on 91 more. One hundred ten clinics were maintained by states and counties in prisons, reformatories, homes and orphanages. Seventy-four clinics were under Federal control. Industries, trade unions and fraternal organizations had established 84. Ten were run in connection with group clinics and 180 under various lay organizations such as charitable associations, community chests, the Red Cross and religious organizations. Twelve could not be classified under any of these groups.

How the Clinics Are Distributed

Of the 462 clinics under hospital control, 94 were in state hospitals and are not considered in the statistics about hospital clinics given in the rest of this article. Of the 368 other hospitals reporting dental clinics, 29 were city hospitals, 24 were county hospitals, 18 were hospitals conducted in connection with medical schools. The remainder could not be classified. In general, clinics in hospitals have not tended to bring in outside control although a few have shared such control in connection with cooperative clinics for school children or other special classes.

Dental clinics exist in every state in the union. Over a third were in Pennsylvania, Massachusetts, New York and Ohio. In contrast, Mississippi, Nevada and Wyoming each reported only one clinic. Over 80 per cent of the clinics have been established in the East and Middle West. Clinic service is almost entirely an urban development. The larger a city, the greater is the number of clinics within its borders. Sixty-six per cent of the hospital dental clinics were in cities of 100,000 population or more, 21 per cent in cities of from 25,000 to 100,000, 7 per cent in cities between

[1] Leuck, Miriam Simons, A Study of Dental Clinics in the United States, University of Chicago Press, 1930.

10,000 and 25,000. Board of education clinics reached their chief importance in cities of from 25,000 to 100,000 and board of health clinics in the somewhat smaller communities. Industrial and charity groups were largely in the big cities.

In cities of 100,000 population or more, the hospitals provided 40.9 per cent of the total number of clinics, their importance sinking to 22.2 per cent in the next size cities and decreasing rapidly as the cities grew smaller. No other single agency even approached the hospital clinics in importance in the large cities, the nearest group, the industrial, providing less than 9 per cent of the total number of clinics in those centers. In cities of 25,000 to 100,000, however, there were more board of education clinics than hospital clinics and in the cities of 10,000 to 25,000 the board of education clinics made up 30 per cent of the total as compared with nearly 12 per cent controlled by the hospitals.

As with clinics of all types, the largest number of hospital clinics (36 per cent) were in the Middle Atlantic states and the smallest number, 3 per cent or less, in the South Central states and the Mountain states.

Dental care was given during 1930 to 1,962,791 patients by the 80 per cent of the clinics reporting the number served. Statistics on visits are of little value in the dental profession because they vary from operator to operator, from institution to institution; for example, a clinic which prefers to keep the sittings of patients of equal length will require one or more visits in order to complete an operation which, in another institution, would be finished in a single session. Since many clinics, particularly those connected with hospitals, record only the number of visits, however, a report on visits was requested to assist in classifying the extent of service rendered. The 804 clinics who replied to this question reported 2,796,147 visits in 1930.

Serving Cities of All Sizes

The possession of one or more chairs by a dental clinic is an indication of its present or potential service, and its intention to provide continuous rather than strictly limited dental treatments. A request for the number of chairs possessed by the clinics, therefore, was included in the questionnaire sent out to the clinics. One thousand one hundred fifty-three clinics reported the possession of 3,315 dental chairs, or an average of 2.8 chairs per clinic. Two-thirds of these chairs were in clinics in cities of 1,000 population or more. A five-chair clinic in a city of 1,000,000 population is relatively unimportant in the mass of dental service rendered in that community; a five-chair clinic in a city of 2,500 inhabitants, on the other hand, (unless in an institution with its services limited to the inmates), may absorb the entire dental work of the area.

The statistics indicate that in the larger cities (with a population of 100,000 or more) there was one chair to each 12,500 persons, while in cities with populations from 5,000 to 10,000 there was an average of one chair to about 6,650 persons, and in towns with a population of 1,000 to 2,500, an average of about one chair to about 1,800 individuals. Hence, although but few small towns have dental clinics, when a clinic does exist in such a community, it may play a larger part in the service of the area than it would in a larger city.

Majority of Patients Are Children

The largest number of chairs, 225, was reported in a dental school clinic. Such clinics never use all of their chairs to full capacity and are practically all found in large cities. These facts must be taken into consideration in measuring the amount of clinic service generally available in large communities.

The clinics studied varied in size from small one-chair units serving school children or community charity cases to clinics established by endowments or similar agencies which serve tens of thousands of patients annually. The 1930 survey indicated that one-fifth of all the clinics in the country serve less than 174 patients a year. In contrast to this another fifth served between 2,000 and 100,000. The number of patients cared for by the other three-fifths ranged from 175 to 2,000. One-third of the clinics serving the largest numbers were in cities of 100,000 or more. There is a considerable difference of opinion among those interested as to whether the most significant developments in the field are the few large endowed clinics or the many small ones.

Fifty-one per cent, or 1,006,918, of the 1,962,791 patients reported were children. Thirty per cent, or 596,956 were adults, and 18 per cent, or 358,917, could not be classified. Forty-eight per cent of the clinics reported accepted only children; 16.7 per cent admitted only adults and 34 per cent took care of both. The remainder failed to report. Dental clinics in hospitals have a greater tendency to serve both children and adults than do dental clinics as a whole. Of the hospital clinics, 79 per cent offered their services to both, 8 per cent served adults only, and 10 per cent served only children. Dental school clinics were the only other important group which served both adults and children. Industrial clinics, the Veterans' Bureau, the Public Health Service and the state correctional agencies limit their service to adults, with few exceptions. Boards of education, boards of health, charities, health associations, lay and fraternal organizations are as

strikingly interested chiefly in children's dentistry.

The extent of the need for dental service is indicated by the fact that dental clinics have been established under such varied lay auspices. Not only have such groups as the charitable organizations, the Red Cross and the Visiting Nurse Associations established clinics, but clinics have also been sponsored by groups as varied as the American Legion, Babies' Milk Fund, churches, fraternal organizations, settlements, the Junior League and the Y. W. C. A. Local conditions and demands undoubtedly have been the determining factors in bringing most of these types of dental clinics into being and, on the whole, where they succeed, the tendency is for them to be taken over by some governmental agency.

The types of service rendered by these dental clinics varied from simple prophylactic treatment given in clinics without chairs to complete dental service. Some clinics do emergency work only. In the space on the questionnaires reserved for "Remarks," a few hospitals reported that they limited their clientele to particular types of patients, such as tuberculous, mental or maternity cases. Four reported that their service provided examination only, 20 limited it to extraction, 3 to x-rays and 45 reported other limitations. Fifty-two stated that full dental service was rendered.

Although no questions were asked regarding fees or size of staff, as these were to be included in a special study of hospital dental clinics which is now approaching completion, a few volunteered the information that indigents only were treated, that service was rendered without charge to social service cases or that only a nominal fee was charged. Several reported the use of interns in the dental division. Approximately 150 hospitals have been included in the detailed study of such clinics now under way, which will deal with such questions as relations between the hospital and the dental division, the size of the staff and the rate of payment, admission requirements for patients, the fees charged, the operating expenses, and the types of services rendered.

"Subsidize Nurse Training Schools," Says Canada Survey

That training schools for nurses should no longer be left to the haphazard methods of individual hospitals, but should be subsidized, controlled and supervised by the Government in the same way normal schools are, is emphasized throughout in the recently published Survey of Nursing Education in Canada. Training schools run by hospitals, under present conditions, actually represent a financial liability instead of the asset they are commonly supposed to be.

"An approved training school should be defined by law," the survey suggests, "and hospitals, otherwise qualified, should not be legally authorized to establish training schools unless on the explicit written statement of the provincial board of control, to the effect that the supply and demand situation among nurses and the needs of the community warrant the establishment of such a training school."

The following headings will give an idea of some of the other subjects covered by the survey:

Educational Standards, under which are discussed preliminary education, the content of the curriculum, the R.N. examinations, the lecture method in the classroom, housemaid's work, the size of the hospital conducting a training school, and theory and practice; Oversupply of Nurses; Distribution of Nursing Services; Socialized Nursing Service under which are presented the topics of the principle of ability to pay, the reorganization and control of nursing services, the Federal Council of Nursing, provincial councils of nursing, district registries and compulsory state health insurance under defined income limits for wage earners, salaried persons and those who enjoy a certain financial independence, such as small merchants, retailers, druggists, butchers, bakers and farmers.

Survey Reveals Many Prescriptions Inaccurately Filled

Of 100 prescriptions filled recently by druggists in the District of Columbia for Federal officers, sixty-seven were found to have been filled unsatisfactorily, the Federal Food and Drug Administration, Department of Agriculture, announced recently.

Statistics on the accuracy of filling of prescriptions throughout the United States are not obtainable by the Food and Drug Administration, since its jurisdiction covers only drugs moving in interstate commerce and drugs in the District of Columbia and in the territories, it was explained.

State and city health officials, however, have authority to make surveys of the satisfactoriness of the druggists' work, and it is thought possible that the action in the District of Columbia may attract enough attention to result in such surveys.

Included among the prescriptions were fifty-nine covering United States Pharmacopoeia products, and thirty-seven of these were unsatisfactory, twenty-seven containing an excess of active ingredients or being below the allowed tolerance while ten were excessively short measure.

Practical Administrative Problems:

How to Have a "Well Kept" Hospital in Times of Economic Stress

FORMERLY no perturbation of the superintendent's official calm resulted when there came to his desk the monthly balance sheet setting forth the expenditures and receipts of the institution. Today, the monthly financial reckoning is a matter to which those in authority look with considerable anxiety. While no institution serving the sick and caring for patients of all economic classes can long deserve the patronage of the community if it expects to profit financially by its activities, still balance sheets have not always been the fearsome documents they are today.

During the past few months, a sort of panic has overtaken those responsible for the conduct of the hospital because of the daily mounting of the always worrisome deficit. Because of the psychologic effect of this fear the institutions of the country are now perhaps less efficiently maintained than at any time for a considerable number of years. Retrenchment has been necessary on every side. Money has often been saved only to be lost because major repairs have been necessary, when at one time a minor expenditure would have been effective.

Do Not Allow Repairs to Accumulate

THE MODERN HOSPITAL has repeatedly emphasized the fact that it is not a wise business policy to allow necessary future expenditures to accumulate, even though access to endowment funds must be sought or temporary loans must be made. To be sure, there is a type of institution which having with difficulty met its current bills in fair times finds itself in a sorry state now. It is a question whether such a hospital should not immediately seek other and unexplored avenues in a search for the solution of its problem, rather than continue to incur deficits which probably never can be met. To do otherwise smacks somewhat of spiritual, if not financial, dishonesty. In order to render the fullest service to patients, therefore, it is necessary to consider the necessities of a time when incomes will be increased but in which pressing expenditures for repairs and rebuilding will far exceed such additions to the hospital's income.

It is an exceedingly shortsighted policy for a board of trustees to permit the physical repairs of the hospital to be neglected because of a temporary shortage of funds. Costly machinery, requiring now a relatively small outlay for inspection or rebuilding, may soon reach the stage where the expenditure of thousands of dollars will be required should a breakdown occur. It is the purpose of this article to consider some general principles relative to the methods by which the institution may be kept in repair and to point out the wisdom of just as careful inspection and of even more thoughtful planning as to the maintenance of the physical plant now than in more fortunate economic times.

Taking Advantage of Present Wages

As has been mentioned previously, few administrators have experienced a time when the services of painters, plasterers, bricklayers and mechanics of all types could be obtained as cheaply as at present. The great army of the unemployed containing as it does many skilled artisans is daily knocking at the door of the hospital and asking to be engaged at the hospital's price. If major or minor repairs can be completed or indeed if in the case of institutions happily in possession of adequate sums of money for rebuilding, a comprehensive construction program can be adopted, with vision, not only will this save large sums of money for the institution but also the prosecution of this policy will, as a by-product, supply work to those who direly need it.

The hospital does not reach a condition of disrepair in one day. Nor can it be restored to a satisfactory physical condition in a short period. None will dispute that the hospital should be a model of orderliness and sanitation. Plumbing must be maintained in the best of condition. The safety of the lives of the patients demands nothing less than this. It is economy to eliminate leaking hot water spigots and to repair defective roofs. It is but an act of wisdom to inspect elevators, both for safety and for the need of minor adjustments. And so the inspectorial service of the hospital, whether it is provided by the superintendent or by one of his agents, must be just as carefully and faithfully maintained now as it was formerly, even though funds may not be immediately available to

remedy the defects discovered. To do otherwise would be to dwell in a fool's paradise and to postpone a day of reckoning, the necessity of which will be difficult to explain to the community.

In many institutions, adequate inspection policies are not practiced. Often the head nurse on each floor is expected to originate requisitions for upkeep services. It appears that first it is the plain duty of the superintendent of the hospital frequently to visit, with the proper subordinates, every part of the hospital plant and thus at first hand to obtain information in regard to the functioning of the many groups of his personnel family. Such visits stimulate morale and thus bring about a more painstaking attention to the physical side of hospital administration.

No useful unit standards have been developed relative to the usual cost of maintaining the hospital in repair. Many variables enter into the problem, such as the type of the plant, whether it is new or old, whether it is constructed on a composite or a detached plan, and the condition of the help market. Wages may be too high or too low. The organization of the institution may be loose or compact. Inspections may be made only at long intervals, and even then, performed carelessly and without proper attention to detail.

To the superintendents of many institutions, it may appear somewhat ill-advised if not impertinent again to suggest that the time to repair a building and to maintain it in a cleanly condition is when it is being constructed. Many an institution exists today in a state of obvious disrepair because of a failure on the part of someone to recognize the importance of providing efficient measures by which to keep it in condition, once it is built. In a certain institution it is necessary, for example, to engage carpenters at frequent intervals to construct a scaffolding in order that the outside surface of operating room windows may be cleaned. No thought was taken of the necessity of providing for the performance of this necessary work when the architect's plans were being studied. In another, thousands of dollars have been spent in replacing crumbling plaster because proper air spaces were not placed for ventilation so that walls would not sweat.

When Minor Repairs Are Neglected

It is certainly much cheaper to repair than to replace any section or surface of a hospital building. The hospital in which doors sag, plaster crumbles, terrazzo floors crack and plumbing fixtures leak, may be the very institution in which an all too meager repair force is endeavoring to make some major additions, because of a fine construction zeal possessed by a shortsighted superintendent. It is certainly a mistake to meet too promptly the demands of an insistent staff member or of a nonunderstanding trustee by readily agreeing to use the hospital's own mechanics to build an addition to the x-ray department or to the kitchen, while less dramatic minor repairs remain untouched. This is a practice that too frequently prevails throughout the hospital field. Even at the expense of engaging outside engineering help, obtaining bids for relaying a floor, or reorganizing or rebuilding a private unit, this policy is often in the end the least expensive.

How the Board Building Committee Can Help

There are too many hospital board members who would never neglect to learn the details of a costly addition to their plants, but who more or less readily acquiesce in the adoption of a poorly conceived hospital building program that resembles the questionable policy of placing new patches on old garments. A committee of the board of trustees, which may be known as the building committee or the committee on physical plant, should endeavor to work out with the superintendent a comprehensive plan for the maintenance of the hospital or for the construction of any new units that may be contemplated.

There are usually mechanically minded board members whose opinions if they are sought will save the hospital many dollars. Such board members are frequently not willing to accept without careful scrutiny the somewhat ethereal and roseate word pictures presented by overenthusiastic professional members of the hospital personnel. To be sure, the superintendent of the hospital must not allow himself to be placed in the position of appearing to hold back when it comes to things progressive, but just as certainly he should, if possible, knowing every detail concerning the condition of the physical equipment of his plant, originate requisitions before they are presented to the board by others. Nor should the vision of the inspector be leveled only upon indoor needs insofar as repairs are concerned. To allow roofs to deteriorate because of the need of waterproof paint, or iron work on fire escapes to become weakened because of the necessity for the expenditure of a large sum of money for paint and labor is, as all will recognize, a shortsighted plan.

The superintendent sometimes adopts a fainthearted policy in the light of pressing financial needs and fails to recommend to his board the expenditure of money for repairs. By so doing, he takes upon himself a responsibility he is often unable to bear. By this act, he is postponing a time when he must face his board and request the appropriation of large sums of money because he failed,

at the time the need became first evident, to apprize his superiors of the necessity for action.

In almost every community, from funds that have accumulated as a result of public contributions or drives, it is possible to obtain the services of persons who are unemployed, and thus, in a measure at least, to avoid falling too far behind in physical plant maintenance. To be sure, it has been claimed by the slothful superintendent that it requires more supervision, cajoling and encouragement to derive material benefit from this group than their services are worth. Yet the superintendent endowed with a practical mind, by carefully appraising the group supplied him, may find persons particularly well equipped along lines which, if developed, may serve satisfactorily to meet some definite needs of his hospital.

To be more specific, it may be said that once a thorough and routine inspection plan has been adopted, the first step toward securing the proper upkeep of the hospital has been taken. The inspection of a hospital, however, consists of more than a day's stair climbing with a pencil and notebook much in evidence. There must be a display of a practical intelligence as to the amount of labor available and as to the relative time necessary for meeting the needs discovered. A certain amount of mechanical knowledge is necessary. For example, the ventilation of an overheated drugstore, clothes' room, or ward area requires more than the mere discovery that these spaces are uncomfortably warm. The superintendent, therefore, may not always maintain his institution in the proper condition with the least expenditure of money while sitting in his office.

Following Up Repairs

Perhaps one of the chief defects of hospital maintenance lies in the failure to develop an efficient follow-through from the standpoint of mechanical upkeep. A leaking water pipe requires, first, the attention of the plumber; next, perhaps, that of the carpenter; then the plasterer, and finally, the painter. In a small hospital, all of these trades may be represented by one man-of-all-work. Fortunate indeed is the superintendent who possesses this gem among the members of his hospital personnel. Frequently, one observes a water pipe that has been repaired. If no follow-up system has been enforced, there remains for weeks after a gaping aperture in the lathe and plaster. The expense of repairing but one defect of this sort, consisting as it does of repeated inspections, the writing of many requisitions, the making of many telephone calls, not to mention the accompanying unsightly appearance, is considerable.

If there is a foreman of maintenance, it is his duty not only to discover the need for repairs, but also to see that covering requisitions are forwarded and are effectively and promptly filled. There is one defect that many mechanical foremen possess. It is a certain passivity, an inclination to temporize in the face of a difficult and time consuming repair job rather than to create work for themselves and for their subordinates. Whether this sort of service includes the need for the repair of a medicine closet, the replacement of a door knob, the rebuilding of a ward chair, or the entire replastering of a floor, attention to the first requisition should not be delayed.

The Dangers of Procrastination

There is a type of mechanical foreman, and indeed, perhaps this trait is possessed by some superintendents, who procrastinates until the protestations from those desiring repair services become so insistent that further delay is impossible. Such executives, not without pride, boast of always placing the first two requisitions in the wastebasket and of awaiting the receipt of the third before they act. Such an ignoring of the receipt of a requisition, no matter how preposterous or expensive, is sure to destroy morale and to discourage the future reporting of needed repairs.

In these days of strife and financial strain, it is difficult enough to maintain a high institutional morale without adding new factors. It is best for some sort of a reply to be made whenever a request for repairs reaches the superintendent's desk. It may not be possible at the time to take prompt and complete steps to fill the requisition, but some word should reach its originator, and whether explanations are scant or comprehensive they must in a measure at least be more satisfying than a frequently misunderstood silence on the part of the superintendent.

The need for repairs, therefore, which may be considered as minor, still has inherent therein not only the necessity for physical aid in the care of the sick, but also much of a mental effect on those who are daily forced to perform their work thus handicapped. The proper plastering and painting of ward and work areas create a desire to maintain a cleanliness that is difficult to obtain when more or less drab and squalid ward walls and ceilings daily meet the gaze of the worker. The members of the hospital personnel can observe and appreciate such needs, whereas they might not be able to understand the knocking of a moving part because of lack of lubrication or the ineffective operation of an elevator because its motor needed overhauling.

The superintendent should require the members of his mechanical force to place on his desk regu-

larly a certification that a proper inspection has been made of the boiler plant, the elevators, the sterilizers and of all other complicated and expensive equipment. If this is not done, mechanics, usually being of a less methodical turn of mind than the superintendent, may postpone from day to day such inspections until costly accidents happen which may even endanger life. In a certain institution equipped with an expensive but efficient, even if complicated, belt coal conveyor, an inspection that was to have been made as each power house trick went off duty was omitted on a number of days. As a result, a minor defect developed into a major one, and a breakdown occurred that cost several thousand dollars and ruined the efficiency of the plant for weeks.

Elevators and Their Maintenance

All such failures of inspection do not result as disastrously, but in every part of the institution nine stitches are frequently saved by one taken in time. The elevator service is one of the most important utilities the hospital possesses. The movement of the patients from floor to floor, the possibility of the necessity for its emergency use in the case of fire, the general convenience and, indeed, the health of the hospital family depend upon smoothly and efficiently operating elevators.

Many hospitals do not possess a skilled mechanic upon whose judgment and advice the superintendent can act insofar as the maintenance of elevator repairs is concerned. Those who manufacture this important machinery frequently offer such a service on a yearly plan. This covers inspections at proper intervals and supplies necessary labor and materials for repair. Such contracts are not cheap from the standpoint of the annual outlay necessary, and yet in the long run they are probably more economical than to run the risk of a major breakdown with the accompanying necessity for the outlay of a large sum of money. In order to arrive at any conclusion as to the advisability of entering into such a contract, it becomes necessary for the superintendent to have available a statement of past maintenance costs.

In many hospitals, one seeks in vain for a requisition slip upon which the repair expense in time and materials is set down. Rare indeed is the superintendent who is able to learn in any accurate way the number of hours spent by a hospital mechanic in performing any given job and who has made any successful effort to record the total expense to the institution for this work. If an inspection and checking system is in force, the originator of the requisition or the foreman of mechanics is usually required to certify that the repair has been properly made. The original requisition slip or a copy of it should eventually reach the superintendent's desk, with proper notations on it as to the complete cost of the work. A mechanical force that adopts a purely passive attitude and with folded hands awaits a requisition for its services is rendering an indifferent service to the institution. A high morale among such workers should result in the generation of a real pride in the appearance of every portion of the hospital.

What are some of the steps to be taken in order that the hospital may always display a well kept appearance, which after all represents but a thoughtful attention to detail? Spray painting has been heralded far and wide as a solution to the problem of preventing the shabby appearance that many institutions present as to both the interior and the exterior of their shell and also to the building contents. One of the chief obstacles to the adoption of this policy comes from the hand painters themselves. The danger of lead poisoning, the possibility of the ill effects of machine work upon an ancient and honorable trade and the expressed belief as to the inferiority of painting with compressed air are threadbare arguments against this innovation.

A proper spraying machine, well handled, can in straight work cover as many square feet of wall space in a day as could from four to six hand painters. To be sure, some paint is lost, and depending upon the type of material employed there may be some slight truth in the statement that harmful lead particles may be inhaled, if this base is used in the paint. But there can be no argument as to the efficiency of spray painting, or as to its applicability to the needs of the hospital.

A Repairs Slogan for the Executive

The superintendent who has not looked carefully into the economy of the use of such an apparatus and into its efficiency when well handled has missed a fine opportunity of saving money for his institution. The slogan of the hospital executive should be, "Paint when necessary; repair toilets, rain spoutings and roof copings when they require attention." If he is unable to perform this work promptly when its need is discovered, the responsibility for this omission should be placed squarely upon the shoulders of the members of the board.

It may be said, finally, that as building costs have declined 50 per cent in the past two or three years and as skilled mechanics gladly accept work at about 33 per cent less per hour than formerly, the superintendent should consider the wisdom, even the life-saving effect, of putting forth the most strenuous efforts to secure funds to maintain the physical plant of his institution in a high grade of repair and efficiency.

Editorials

"Cured"

IN POINT of age, the theory that the fundamental duty of the hospital is to cure its patients, if it can, is the oldest. Later developments came in the educational research and preventive programs that were elaborated with time, but the need remains for definitions that will enable everyone concerned to draw conclusions from figures based on terms that are universally understood to mean the same thing.

When is the hospital justified in considering a patient cured? According to the dictionary, cure means "restoration to a sound or healthy condition; to bring about recovery, as from disease." Although the term is in universal use in hospitals it might mean anything in actual practice from the complete cure that results, let us say, from the successful excision of a superficial benign tumor, to the kind of cure that is taken for granted by the medical staff when the patient is discharged from the hospital, relieved of his most pressing signs and symptoms, in order to make room for the next patient.

But, does "cured" refer to signs and symptoms only, or to the underlying disease of which they are the evidence? Very often, too often in fact, a patient is recorded on discharge as cured, who is cured only of the effects of the surgical operation rather than of the disease for which he was operated upon. Let us consider as a familiar example, the removal of a so-called chronic appendix in a patient who has suffered vague abdominal discomfort over a long period of time, in whom all other kinds of organic disease have been ruled out by exclusion and in whom the discomfort returns and persists some time after his discharge from the hospital. The mere relief of signs and symptoms is the more primitive type of "cure," while the relief of the underlying condition is a modern achievement.

Thoughts like these provoke a number of questions. Is it correct, in most instances, to label a case "cured" on discharge after the current practice of most acute general hospitals? Would it be desirable to recommend that the use of the term "cured" be delayed, except in the most obvious cases, until an adequate period of follow-up care has been given to determine the remote results of treatment? What should be the liability of a hospital, legal as well as moral, for uncured cases that have been discharged as cured after a short term of treatment? In other words, is the responsibility of the hospital to treat signs and symptoms and merely give relief, or to cure as required by definition, if a cure is possible under the circumstances of the patient's illness?

If the more modern definition of the word "cured" be accepted by the hospital, would it not be fair to ask for the adoption of a unit record system which would contain in one folder the clinical biography of the patient throughout his life in the in-patient and out-patient departments and show, accurately, the stage in which the cure took place? What is the relation between the acute general hospital and the chronic hospital (accepting the current notion that the latter is the follow-up department of the former for patients that are non-ambulatory) from the standpoint of the definition?

The use of the term "incurable" should be condemned as conveying an atmosphere of finality about the patient, as if the social agents had passed a life sentence from which there is no appeal. How safe is the word "cured," not alone from the point of view of hospital statistics but from the scientific point of view and from the point of view of the patient with whom the hospital presumably breaks when this apparently favorable verdict is announced on his discharge from the hospital?

Diagnosis has an important time element and so has therapy, but prognosis should always be guarded, if for no other reason because in medical life we are almost always dealing with cases that are unprecedented in character, and there need be no hurry about stamping a case cured until it is definitely and finally known to be so from all of the scientific facts at our disposal, including the element of time. There ought to be a rule in scientific medical societies requiring a check up of all cases reported cured within a year or so after the claim has been made by the physician.

Meantime, there are more accurate expressions such as "healed," "relieved," "improved," "arrested," "quiescent," that might return to vogue alongside of the term "cured." Perhaps it would be wisest to limit the use of the term "cured" to the follow-up clinic and remove it entirely from the terminology of the ward statistician. We should then at least be free of the possible accusation that we are taking too much responsibility on ourselves (and credit) for so describing the condition of the patient on discharge; and the contributing public, which sees in large figures under the heading "cured" justification for its philanthropy, will learn to appreciate our thoughtfulness for the sick by our guarded methods of administering to their welfare.

How long is it since the value of the hospital to the community was measured popularly by its mortality rate? No decent hospital would now think of selecting its patients on the basis of the comparative risk involved, and no hospital should hasten to claim cures until they have been established in the follow-up clinic beyond a reasonable doubt.

Death Rates and Politicians

MANY times the editorial columns of this publication have contained editorials in which the political type of hospital has been referred to and in future issues the same subject will be further discussed. There is no more terrible place in the world than the hospital that has fallen under the machinations of political shysters, and to healthy minds it is unthinkable that human lives should be sacrificed to make fat pocketbooks for loathsome creatures who through all kinds of chicanery, corruption and crime are today holding high offices in their communities.

If anyone reading these lines doesn't think that lives are needlessly sacrificed in these institutions, let him review these figures that have recently come to light regarding the most famous and at the same time the most infamous of these hospitals. We quote excerpts from a survey that was made by an extremely reliable agency:

"In the boldest and frankest terms, reduced nursing personnel means a reduced standard of nursing care which in turn simply means a higher death rate, more funerals, more tombstones, more sorrow and distress not to say anything of increased suffering and chronic invalidism. This responsibility must be placed. With an annual death rate of 41 per cent in the tuberculosis wards, of 12 per cent in the infectious wards, of 14 per cent in the children's wards, of 17 to 21 per cent in the medical wards and of 7 per cent in the general surgery wards, who is there among us who would be guilty of contributing further to this sad picture?

"I will just mention a few of the conditions:

"The overcrowding of wards at times not only with bed patients but with out-patients who are examined and treated in rooms adjoining the wards. . . .

"The marked lack of essential and adequate equipment for rendering nursing care. . . . .

"Insufficient number of bedpans and sets of equipment to individualize technique when desirable because of contagious conditions.

"Lack of utensils, instruments and bedpan sterilizers on many of the wards and units.

"In respect to the shortage of bed screens in many of the wards, I frequently found patients, male and female, having their physical wants and treatments attended to in full view of the ward. . . .

"The lack of sufficient sets of instruments on many of the wards to do surgical dressings.

"In my survey I found more than the usual number of postoperative infections."

It all reads like the fourteenth century and from some remote part of Europe. But it is not. It is in one of the largest cities—and incidentally one of the most politically corrupt—in the United States, and the statement was made in March, 1932.

When bootleggers, racketeers and speakeasy proprietors become the rulers in any city the same condition may be expected. Life and death particularly among the poor and uninfluential mean nothing to these hoodlums. To raise hospitals to the high standards they have reached or to reduce death rates to the low point they have reached are no achievements if those interested in better hospitals are to allow this sort of institution to prosper.

Many reputable manufacturers will not sell to these political cesspools because it is too costly, and they will not stoop to handing out graft. The better types of physicians and surgeons are fast leaving them.

It is time that the American Medical Association, the American College of Surgeons and the American Hospital Association, in behalf of the good name of its members, make a full and unbiased investigation of every one of these institutions and the contemptible men who are using them for personal gain. For instance, to rate the particular hospital referred to as fit for intern training is an affront to honest hospitals and honest medical practice. To put it on the approved list of the American College of Surgeons is an insult to hospitals that have honestly brought their standards up to meet the minimum requirements.

It is time to act and it is the sincere hope of all reputable hospital administrators that these groups act promptly, fairly and mercilessly.

Educational Contributions to the Hospital

IT HAS been repeatedly asseverated that the hospital which does not seriously assume its educational responsibilities is falling far short of fully performing its duty to the community. Not only must the hospital cure those afflicted with disease but with no less certainty must it prevent illness and educate others to do so. The institution that is not blessed with an educational vision is doomed to stagnation, to scientific death through dry rot. And, in the course of rendering a teaching

service to hospital workers, the hospital also realizes for itself much that is of practical value in its operation.

Loud protests have been raised here and there in the nursing ranks relative to the iniquitous profiteering on pupil nurses by poorly conducted training schools. Some justification is at times to be found in these complaints. But in the most efficiently conducted school the pupil nurse is likely to give more than she gets. She gives in service to the sick and in a definite manner she is the source of a certain scientific stimulation which teaching ever supplies. The training of interns and the instruction of technicians in laboratory, clinic and occupational therapy departments is a means of obtaining much practical aid in the care of the sick at a low cost.

The magnitude of the sum total of assistance in performing the work of the hospital day, however, only serves to direct attention to the institution's obligation to recompense amply the members of these groups by generously providing for them sound educational opportunities. To remove all educational activities from the hospital would not only deprive it of a great source of loyal, conscientious service but it would also extinguish the spark that kindles and keeps at a bright glow the fires of high morale and of spontaneous self-sacrificing endeavor in the care of the sick.

The Department of Occupational Therapy Holds a Sale

A NATURAL sequence to the year's work in the occupational therapy department is the annual sale of a miscellaneous collection of rugs, baskets, bookracks and purses. From the income thus derived must be purchased the necessary raw materials, the raffia, the wool and the leather, to keep idle minds and fingers busy during the coming twelve months. Many times, only the funds thus derived are available to the therapist for the purchase of these supplies, which have so important a therapeutic value.

He who purchases a basket or a rug made by a patient, however, must be endowed with an inspired vision if he is to evaluate truly the perfection, the beauty of his new possession. For articles that represent the work of the handicapped may appear to the uninitiated as crude and imperfect and unbeautiful. But when the incapacities of their maker, the pain of contracted muscles and joints, the necessary exercise of a will power which will not surrender, the triumph of hope over despair—when all these attributes and conditions are considered in evaluating the merits of the article, it may be transformed into an object of transcendent beauty.

To produce articles of fine lines and workmanship is to be desired, but of far greater importance is the therapeutic effect upon the patient which accompanies their making. The former is a happy coincidence; the latter is absolutely necessary to justify the existence of occupational therapy work in the hospital.

Diagnostic Necessities

TO THE physician of other days a glittering array of costly and complicated diagnostic instruments was never available. His estimate of the nature of the illness was obtained through measures less precise perhaps and yet more dependent on his own inherent abilities.

The accuracy of modern diagnostic attempts is often almost wholly dependent on the report from the institution's various specialized laboratories. As a result, here and there is observed a certain professional slothfulness which appears to be a product of present day practices. It is possible that because of this trend, the fingers of the physician are becoming less diagnostically sensitive and his eyes less intelligently acute to detect signs of disease. The stethoscope, mayhap, is considered less than formerly a necessity because the revealing services of the x-ray are so easily and, to the doctor at least, so inexpensively at hand.

But, is it not possible that the splendid and often indispensable contributions of the electrocardiograph, the x-ray and the clinical laboratory are being abused? Is it not probable that the hospital is being asked to bear the unnecessary expense of providing such specialty information when a more careful study by the physician would suffice? There is not a little of reason in the contention that the patient pays the physician's fee for a diagnostic service which he does not render but for which he is expected to reimburse again a hospital specialty activity. There is, it is feared, in this tendency to abuse these diagnostic facilities, a real danger to the good reputation of and the trust in scientific medicine.

Let there be no chicanery or any semblance of false science in the use of instruments of precision. Moreover, to expect private patients to pay for needless specialty examinations is inexcusably unfair. The aid of the x-ray in the study of ward patients should be sought whenever necessary. If every such study were ordered only after mature consideration of the patient's condition by the visiting physician or his associate, an immense saving would result to the hospitals throughout the country.

NURSING AND THE HOSPITAL

Conducted by M. HELENA MCMILLAN, R.N.
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Safeguarding the Health of Student and Graduate Nurses

By ELLA VAN HORN, M.S., R.N.
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A NURSES' school as an educational institution should seek to further the happiness, to develop the technical efficiency and to increase the capacity for social service of its students. If these are the primary motives of a nursing school, then we have no right to accept young girls into our institutions, to use them for the furthering of our own interests and to return them to society as graduate nurses in poorer physical condition than they come to us.

It seems paradoxical that such movements as preventive medicine and the improvement of public health should have been developed by the medical and nursing professions and yet that these same professions should be backward in safeguarding the health of their students. It is true that student health service is better and more widely organized in colleges and universities than in nursing schools.

Dr. Caroline Hedger, Chicago, says that the health of the student nurse is the responsibility of two parties—first, the school, second, the pupil nurse and her family. To these two I should like to add the graduate nurse and the employer.

Upon the school falls the responsibility to house, feed and educate the student in a manner that will produce the most efficient nurse possible. The pupil and her family for their part should not expect a nursing school to accept for training physically unfit students. Neither should the student expect by entering a nursing school to obtain free medical and hospital care for known ailments.

The general public does not wish a nurse with tuberculosis, asthma or heart disease to take care of its sick. In spite of this attitude students with just such physical impairments are constantly applying for admission to schools of nursing.

After a student is accepted it should be her responsibility to maintain her health at the highest degree possible.

The graduate nurse is the third contracting party. She is the product of the first two. The health of the graduate nurse depends upon the degree of health she has maintained before training and during training and the care and education she has received during training days. She is responsible not only to herself to maintain the highest degree of health, but to her school, to her prospective patients and to her employers.

The fourth contracting party is the employer. The employer, whether a hospital, a public health organization or a private individual, has a definite responsibility in maintaining the nurse's health. The most efficient nurse is the healthy nurse. A graduate nurse cannot work twenty or twenty-four hours a day 365 days a year without a breakdown. Fortunately, economic conditions make such a situation impossible by limiting the number of working days but not the working hours. The graduate nurse, to keep well, must earn an adequate living wage, must have a working day and week that are in accordance with the best social practice. Employers of nurses, whether hospitals or private and public health organizations, even nurses themselves, are guilty of exploitation of the nurse. From no other group of women except mothers do we make such extravagant physical demands.

What are the specific health problems to be met in maintaining the health of the nurse? Theoretically we have an answer to a large percentage of these problems. The solution of them has been found by preventive medicine. What we need is,

first, a thorough knowledge of our own particular problems; second, an application of the basic principles of preventive medicine to them, and third, an organized unit within the school to apply these measures.

I shall not reiterate all the axioms of preventive medicine, but shall point out a few briefly: adequate living conditions, sanitary and uncrowded; three well balanced and regular meals each day; a balanced program of work, study, sleep and recreation; an eight-hour day and night; a forty-eight-hour week; time for outdoor exercise each day while the sun is at its best; immunization against certain diseases; routine medical and dental examinations; correction of physical defects; opportunities to report illness early; instruction in personal and public hygiene.

Organizing a Student Health Service

In order to make a practical application of these principles, there must be an organized effort on the part of the school to carry them out. The term "student health service" may sound complicated and to introduce such a service may at first thought seem to be impossible. On the contrary, it should be easy for a hospital nursing school to have the most complete and the most effective health service with the minimum of effort.

A simple outline of the equipment and personnel for a student health service follows: There should be a school physician with regular office hours for seeing students and graduate nurse and lay employees and a full-time health nurse in the larger schools. In the smaller schools a staff member should have the responsibility of the health of the students. To the health nurse will fall to a large extent the coordinating of existing health agencies into a health service. There must be provided a school dentist; hospitalization for the sick nurses needing bedside care or its equivalent; laboratory facilities; an opportunity to report sickness twenty-four hours a day without fear of punishment, and immunization against certain communicable diseases. The health education of the student in both personal and public hygiene should be under the direction of this department. These courses should not only contain the standard routine but they should be highly personal, they should be courses in health truly applied to the individual and to the special health problems of the school.

The most important health service any hospital school of nursing can give to its students, in fact its first duty, is to provide adequate living quarters. The second most important service is to feed the students well chosen meals, balanced to provide them with all the necessary food elements.

If a student were given the choice of two schools —one with a well equipped and comfortable nurses' home, well planned and adequate meals, an eight-hour day and a forty-eight-hour week but with no organized health service, and the other, with poor living quarters, crowded rooms and a food budget of ten cents a meal but with an elaborate student health service with no control over the living quarters—I should advise her to go to the first.

The third duty of the school is to plan the work and study load so that it will be within the student's physical capacity, with a comfortable margin to maintain resistance against disease.

Other industries have been forced, in some cases by law, to adopt shorter hours for women workers. An employee performing even the most menial labor in an up-to-date mill has shorter hours than student nurses in most hospitals, to say nothing of graduate nurses, especially private duty nurses. Neither the working day nor the working night should exceed eight hours. One day or two full half-days out of seven should be allowed; one full month's vacation should be given each year.

Class hours should not exceed the number allowed average students in standard colleges and universities. The equivalent of sixteen hours of class per week in a college should be the maximum class load for nurses. This should include floor duty as laboratory work.

Students eighteen years of age and younger, who have not reached their full growth, should be given consideration. They are not physically ready for such a work load as some of our schools impose upon them. Their tolerance for heavy work and administrative responsibilities should be increased gradually. Shorter duty hours with proportionately longer class hours as preliminaries will break the change from high school or college to full-time duty.

The fourth duty is to create an atmosphere favorable to the early reporting of illness. Grant to the student a full opportunity to exercise her health knowledge and to apply it practically to solving her own health problems as far as she is able while in school, as she is taught in hygiene. Place a premium on healthful daily living.

What Is the Extent of the Problem?

What are the specific health problems against which we should safeguard our student and graduate nurses? Before we can make our health program effective we must have some idea of the extent and character of the sickness problem. To know this each school should keep careful records of the type and amount of illness among its pupils.

A study made by the *American Journal of Nursing* in 1931 gives the latest available figures on the health of student nurses. This study showed that

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3,384 students in 33 schools lost 23,323 days from duty because of illness. This makes the average number of days lost by each student 6.7.

Statisticians report that about 2.5 per cent of the general population is sick all the time. The average worker in the United States loses from 7 to 10 days each year because of illness. These 33 schools showed that the average time lost each year varied from 1 to 16 days. It seems only logical to assume that 6 to 8 days as a maximum should be the average number of days lost by each student provided the school maintained a fairly good standard of living and health conditions. This of course is a rough and inadequate standard by which to judge our health condition, but it is one way to measure until better records are kept and published. It seems only logical, however, if a school finds that each of its students is losing as many as 16 days each year because of sickness to assume that something must be radically wrong. The school should at once set about finding the cause for the situation and removing it. The school with only one day lost per student would come about as close to Utopia as is possible, considering the physical condition of most student applicants.

Another item to be studied is the number of cases of sickness per student. How often is each student ill? In one school there were 71 repeaters, causing 181 cases of illness out of a total of 294. One of these repeaters caused 6 cases, her total loss of time being two and one-third months. Such information can help a school to eliminate deadwood.

Controlling the Fitness of Applicants

Probably one of the greatest factors in the health problem and certainly one of the most difficult to control is the physical unfitness of applicants to the school. Too many schools have to take what fate and society send them. Most schools, however, can and certainly should be more particular concerning the health and physical condition of the applicant. An examination at the school as soon as possible after entrance should be made as a routine. Many undesirable candidates can be eliminated at once.

Careful histories should be taken of each student, recording not only her physical condition, sickness record and health habits, but her family history and her possible contacts with tuberculosis. A history of symptoms as well as diagnosed illness should be recorded. These not only help to evaluate the physical condition of the student but aid in giving her intelligent care and health training. Careful selection and the elimination of the most unfit, however, increase the responsibility of the school to maintain the student in good health or in an improved state of health. We cannot demand much and give little. A personal interview and physical examination before entrance is an ideal method of eliminating the unfit, but this cannot always be arranged. Careful supervision and follow-up work during the preliminary period, with a second physical examination at the end of this period will eliminate other undesirables.

We should not only know the extent of the illness problem and choose our students carefully, but we should know what our specific sickness problems are.

Illnesses That Affect Nurses

The study made by the *American Journal of Nursing* already referred to gives the following conditions as causing the greatest loss of time by nurses: (1) gastro-intestinal conditions; (2) respiratory diseases; (3) communicable disease; (4) dysmenorrhea; (5) rheumatism; (6) injuries; (7) infected fingers. The following conditions were listed as causing the greatest number of cases: (1) respiratory conditions; (2) gastro-intestinal conditions; (3) infected fingers; (4) dysmenorrhea; (5) rheumatism; (6) vaccine reactions; (7) exhaustion.

To what extent do these diseases exist before they should be considered either a major or a minor problem? As a check upon the relative incidence of disease and a classification of it into major and minor sickness problems in our schools, it will help us to turn to studies made for the United States Public Health Service by Edgar Synden Stricker, published in reprint No. 989.

In this study it was found that diseases of the respiratory tract cause almost 60 per cent of the total morbidity; digestive diseases almost 10 per cent; external causes almost 3 per cent; general diseases, such as epidemic and nonepidemic types, 11 per cent; circulatory and kidney diseases, less than 5 per cent.

It is true that these figures are representative of the general population, but at the same time we could not expect that the general living, working and other conditions would be on a better plane than would be found in the hospital school of nursing. On the other hand the average intelligence of the nurses, the health training, the knowledge of the location of infection and the technique and means of avoiding infection should be far above that of the general population. Also medical care and the means of prevention by immunization should be at a maximum. These should counterbalance to a great extent any advantages that the general population may have over nurses.

A study of a group of 226 carefully selected student nurses will help us to understand the phys-

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ical condition of the students being admitted to our nursing schools. Sixty-four per cent of these students showed tonsil corrections with remnants showing some pathologic change; 26 per cent had tonsil defects showing pathologic change; 11.9 per cent showed some type of heart defect; 0.8 per cent showed incapacitating dysmenorrhea; 16.8 per cent showed enlargement of the thyroid gland, and 11 per cent gave a history of rheumatic infection.

Major and Minor Health Problems

Serious study leads us to classify these problems into major and minor conditions, which are to a great extent unavoidable.

First under major conditions are respiratory diseases. These show a possibility of being reduced to 33 per cent of the total incidence of disease in a school, and should not exist to the extent that they cause from 60 to 75 per cent of the total illness. Any excess of respiratory diseases will point to undesirable conditions within the school. Gastro-intestinal diseases come second. As measured by the figures for the general population, the minimum of incidence should be about 10 per cent and should not exceed 25 per cent if conditions are average in the school. Rheumatism is third and should not exceed a total incidence of more than 5 per cent. Infected fingers are fourth and the entire group of skin infections must be added before they constitute a major problem. This group of infections shows a possibility of reduction to less than 3 per cent of the total incidence of disease in a school. To this group of major disease problems may be added heart disease as a fifth major problem, not because of the number of cases existing in schools of nursing as much as on account of the amount of impairment and the after-effects following cases of heart disease. This is important from the standpoint of the student nurse, and more so from the standpoint of the graduate who must earn her own living restricted by such a handicap. Tuberculosis, the sixth major problem, does not cause a large amount of illness from the standpoint of incidence, but is important because of its long convalescent period and its effect upon the earning power of the graduate nurse. An excess of 1.5 or 2.2 per cent of tuberculosis in a school of nursing would point to poor living and working conditions. Positive and immediate steps should be taken to reduce tuberculosis to a minimum.

Under the head of minor health problems may be included, first, vaccine reactions. The number of vaccine reactions is governed by the student's reaction to the different types of vaccine and by the methods of administration. Exhaustion is the second minor problem. It is a disgrace to the profession to have this condition listed as a major cause of illness. This condition can be reduced to less than one-half of 1 per cent of the total number of cases of illness within a school. Its existence is dependent upon the quality of the living and working conditions. An excess of cases would show that immediate steps should be taken to reduce its incidence. The third minor problem, dysmenorrhea, shows a possibility of being reduced to less than 3 per cent of the total number of cases. Injuries, the fourth minor condition, should not have a higher incidence than that of the general public. Communicable disease, a fifth minor problem, shows the most practical opportunity for reduction of both incidence and time lost due to illness. The incidence of scarlet fever, diphtheria, typhoid and smallpox can be reduced to zero. A study of the communicable disease situation at the school of nursing, Presbyterian Hospital, Chicago, reveals these data: Out of 226 students examined on entrance, 224 had had measles; 137, mumps; 131, chickenpox; 16, diphtheria; 59, scarlet fever; 210 students tested for scarlet fever and diphtheria gave the following results—118 positive Dick tests; 201 positive Schick tests. All students were immunized to scarlet fever, diphtheria and typhoid by the end of the first seven months. The potential cases of communicable disease are confined to mumps, chickenpox and measles. The result is that in 1930 there were only 2 cases of so-called communicable diseases with the school.

Lowering the Average of Sickness

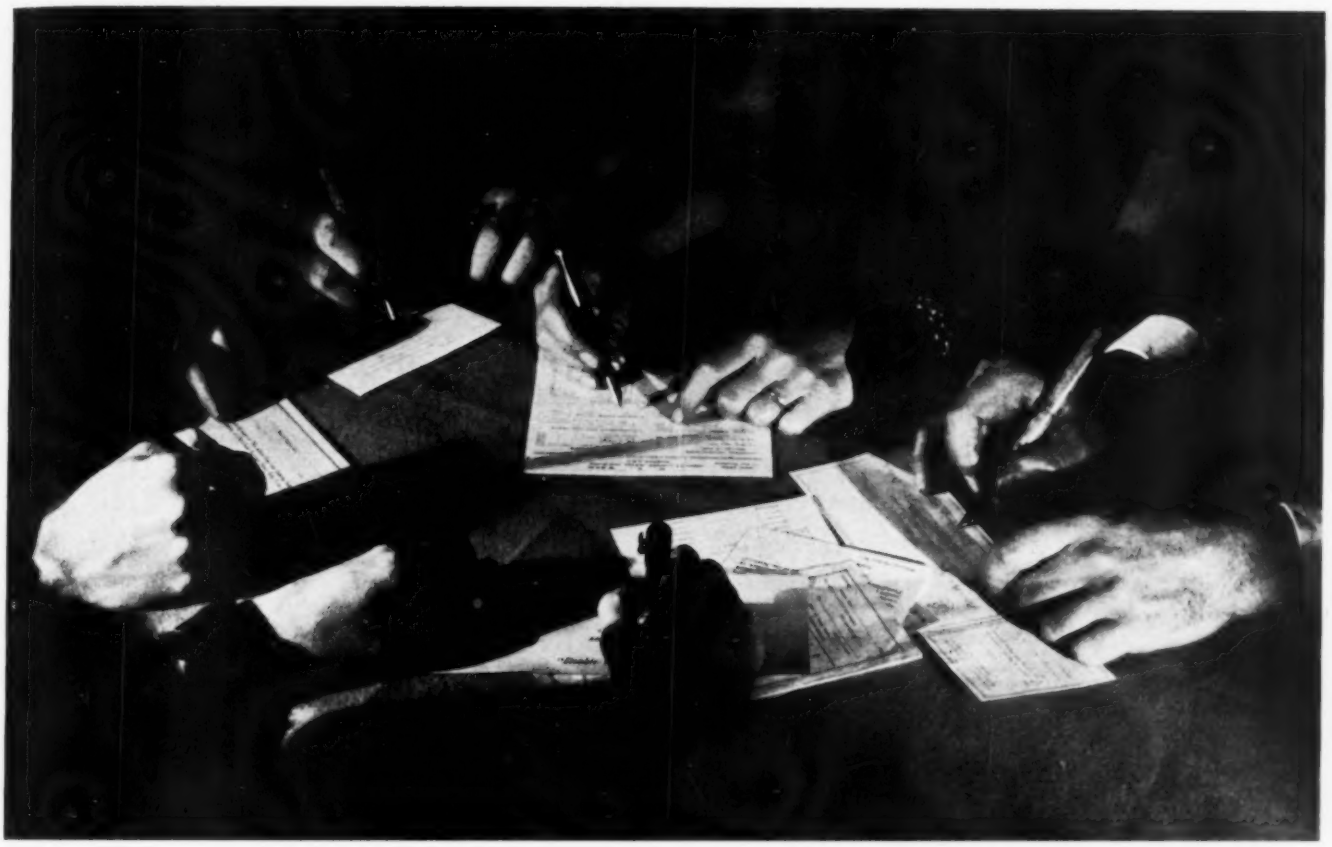
It is impossible to reduce time losses due to illness or to raise the standards of health at once. They will come only after a period of growth, but if the general trend is a lowered average each year, we may feel that ultimately we shall have our students spending a minimum of time off duty because of sickness. A certain amount of time loss from sickness is normal. It is only when the amount is excessively high that we should be alarmed.

Every school will have its own special situations. What would be effective and possible in one school could not be attempted in another even though the need might be great. Every school should study its health problems systematically and then, as it seems wise, work out its own salvation, remembering that a sickness rate in excess of that prevalent among the general population means improper health conditions of some type within the school.

Another test of a school's health is the health of its graduate body. It might be wise for schools of nursing to study the health conditions among their graduates.[1]

[1]Read at a meeting of the Nebraska State Nurses' Association.

Signatures . . .



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NEWS OF THE MONTH

Six Southern States May Join in Meeting Next Year

AT A luncheon meeting held in Memphis, Tenn., on April 19 it was decided that next year an effort would be made to have a joint meeting of six state associations held at a central point. These six associations would be Tennessee, Kentucky, Arkansas, Mississippi, Alabama and Georgia.

The luncheon was attended by the officers of the associations in Tennessee, Kentucky, Arkansas and Alabama, and by J. B. Franklin, superintendent, Grady Hospital, Atlanta, and W. D. Barker, superintendent, Georgia Baptist Hospital, Atlanta, as representatives of the Georgia association. W. Hamilton Crawford, superintendent, South Mississippi Infirmary, Hattiesburg, represented the Mississippi association.

The joint meetings of the hospital associations of Tennessee, Kentucky and Arkansas, held in Memphis on April 18 and 19 proved to be successful beyond the hopes of those who were interested in seeing the states get together. There was a larger attendance than ever before, the delegates numbering over 150. The sessions proved to be of unusual interest.

The first morning was given over to separate meetings by the associations, at which time the officers for the coming year were elected. Agnes O'Roke, superintendent, Kosair Crippled Children Hospital, Louisville, was reelected president of the Kentucky association. Mgr. John P. Fisher, diocesan director of hospitals in Arkansas, was elected president of the Arkansas association, and George D. Sheats, superintendent, Baptist Memorial Hospital, Memphis, was elected president of the Tennessee association.

Dr. Eugene B. Elder, superintendent, Knoxville General Hospital, Knoxville, Tenn., presided at the first meeting on Monday afternoon, and papers were read by Miss Fairfax Proudfit, Memphis, chairman, dietetic section, American Hospital Association, Dr. C. Rufus Rorem, the Julius Rosenwald Foundation, Chicago, and Matthew O. Foley, editorial director, *Hospital Management*. Following this session various hospitals of the city were inspected.

True Southern hospitality was the order on Monday evening when the women attending the meeting were entertained by the Tennessee League of Nursing Education, and the men attended a barbeque some miles out of Memphis. Following the barbeque they attended a wrestling match.

On Tuesday morning Lee C. Gammill, superintendent, Baptist State Hospital, Little Rock, and president of the Arkansas association, presided, and the first paper was presented by Emma Hunt Krazeise, director, Children's Bureau, Louisville, Ky. This was followed by an excellent paper given by W. Hamilton Crawford, which appears in this issue. Miss Lake Johnson, superintendent, Good Samaritan Hospital, Lexington, Ky., presented some interesting thoughts on deferred payments, and Dr. B. A. Wilkes, who represented the American Protestant Hospital Association, summed up the accident cases. Jane Van De Vrede, vice-phesident, American Nurses' Association, also spoke, as did Paul Fesler, superintendent, Wesley Memorial Hospital, Chicago, and president of the American Hospital Association.

Grading Committee's Report Discussed

On the last afternoon Agnes O'Roke, president of the Kentucky association, presided. The first speaker was Jane Van De Vrede who substituted for Alma Scott, and the discussion was given over to the Report of the Committee on Grading of Nursing Schools. The next speaker was Mgr. John C. Fisher on "How Doctors and Surgeons Can Assist in Lowering the Cost of Hospital Care," and an excellent talk was given by Dr. Bert Caldwell, executive secretary, American Hospital Association. The meeting was concluded with a round table by John A. McNamara, executive editor, THE MODERN HOSPITAL.

In the evening the annual banquet was held at which Doctor Elder presided, and Dr. Casa Collier was the speaker.

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NEWS OF THE MONTH (Cont'd)

Texas Association Presents Interesting Program

WITH an attendance of close to 150, the Texas State Hospital Association held its third annual meeting in San Antonio, Friday and Saturday, April 8 and 9. All sessions were presided over by the president, Robert Jolly, superintendent, Memorial Hospital, Houston.

The first paper on the program was the report of an economic survey of Texas hospitals of more than thirty beds, made by John A. McNamara, executive editor, THE MODERN HOSPITAL. The second paper, on sick leaves, was given by Martha P. Roberson, superintendent, Medical and Surgical Hospital, San Antonio, and this was followed by Bryce Twitty, Baylor University Hospital, Dallas, who talked on accident cases and compensation. The last paper of the morning session was given by Ara Davis, superintendent, Scott and White Hospital, Temple, on administrative problems. Following these papers there was a general discussion to which fully three fourths of those present contributed.

The afternoon session opened with a paper by Frances Low, dietitian, Methodist Hospital, Houston, and this was followed by several demonstrations on various procedures in hospitals. The first was put on by Sister Gaberialla, Santa Rosa Hospital, San Antonio, on operating room management, and the second by Ida B. Lockley, Medical and Surgical Hospital, San Antonio, on central supply rooms. Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, then held a round table for an hour, and this was followed by three group meetings, the meetings being divided into superintendents from city and county hospitals, church hospital superintendents and directors of clinics.

Hospital Leaders Speak at Banquet

An enjoyable banquet was held in the evening with three speakers: Paul Fesler, president, American Hospital Association, and superintendent, Wesley Memorial Hospital, Chicago; Dr. Bert W. Caldwell, executive secretary, American Hospital Association, and Dr. Malcolm T. MacEachern. Mr. Jolly presided as toastmaster, and one of the entertaining bits was the report from many superintendents, all of whom had been victimized by a man representing himself as Doctor Phillips or Doctor Carter, of Marshall, Tex. The impostor was recently caught through the evidence of E. M. Collier, superintendent, West Texas Baptist Sanitarium, Abilene. The last feature of the banquet program was the talking motion picture "Hospital Administration," which was taken in Presbyterian Hospital, Chicago.

On Wednesday morning E. Muriel Anscombe, superintendent, Jewish Hospital, St. Louis, gave a paper on nursing economics, and this was followed by a paper on nursing service by Dorothy Rogers, director, college of nursing, University of Texas, Galveston. An interesting round table concluded this session.

The afternoon was given over to business and to the reports of officers and committees. The latter part of the afternoon was spent in visits to many of the San Antonio hospitals.

Switzerland to Develop Dietetics in Hospitals

The Swiss government has formed a dietitian commission along the lines of the American Dietetic Association to develop the science of dietetics in Switzerland to be used in connection with fresh air cures or hospitalization, according to a report from Consul George R. Hukill, Zurich.

At the instigation of this commission, courses are being held throughout Switzerland for those who are desirous of accepting positions as expert or assistant dietitians in hospitals, sanatoriums or hotels. It is felt that in the past, the lack of developments along this line has been keenly felt by the many persons who visit Switzerland each year for the purpose of seeking medical treatment and benefits from the climate, the report states.

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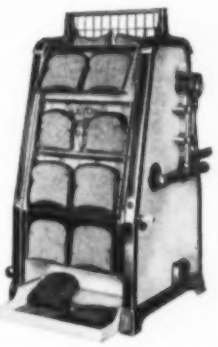

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NEWS OF THE MONTH (Cont'd)

Biennial Program Shows Progress of Nursing Groups

TEXAS hospitality and a constructive program combined to make the biennial convention of the three national nursing organizations—the American Nurses' Association, the National League of Nursing Education and the National Organization for Public Health Nursing—in San Antonio, Tex., April 11 to 15, a significant one in nursing history. Three thousand delegates were in attendance.

Officers elected were as follows: For the A. N. A., Elnora E. Thomson, professor of applied sociology, University of Oregon, Portland, president; Jane Van De Vrede, Atlanta, Ga., first vice-president; Mabel Dunlap, Moline, Ill., second vice-president; Susan C. Francis, Philadelphia, secretary; Emma J. Nichols, Boston, treasurer. The first four named were reelected. New board members are A. Louise Dietrich, El Paso, Tex., Elizabeth Soule, Seattle, Wash., and May Kennedy, Chicago.

For the League: Effie J. Taylor, professor of psychiatric nursing, Yale University, New Haven, Conn., president; Nellie Hawkinson, Cleveland, first vice-president; Julie C. Tebo, New Orleans, second vice-president; Stella Goostray, Boston, secretary; Miriam Rottmann, New York, treasurer. New board members are: Elizabeth C. Burgess, Katharine Densford, A. Louise Dietrich and Shirley Titus.

For the N. O. P. H. N.: Sophie C. Nelson, director, Visiting Nurse Service, John Hancock Life Insurance Company, Boston, president; Winifred Rand, Detroit, first vice-president; Mrs. C.-E. A. Winslow, New Haven, second vice-president; Katharine Tucker, New York, secretary; Michael M. Davis, Chicago, treasurer.

In 1934 the groups will meet in Washington.

The Saunders medal awarded annually to the nurse who has given the most distinguished service to her profession was presented to Annie W. Goodrich, dean, Yale University School of Nursing, at elaborate ceremonies on Tuesday evening.

Of interest to hospital administrators was a recommendation of the house of delegates of the A. N. A. in regard to the custom in some hospitals of accepting payment for the services of student nurses. Says the recommendation, which will be brought to the attention of the governing bodies of hospital and medical associations: "Concerted action by all the groups concerned with the hospital care of patients would speedily eliminate the pernicious practice, which is inimical alike to the best interests of the patients and of the nursing students, since it jeopardizes the comfort and safety of the patients, disrupts the educational progress of the student and is demoralizing to good standards of nursing practice."

A closer tie-up between the A. N. A. and the National League of Nursing Education was also made when the house of delegates accepted the league as the educational department of the A. N. A., with no change in the structure or the autonomy of the league.

Oversupply of Nurses Is Emphasized

Dr. May Ayres Burgess, director, Committee on the Grading of Nursing Schools, in a joint session of the three associations made public for the first time the exact figures on the oversupply of nurses in the United States. No more than 273 days, or nine months of work are available for the average nurse in the year, even if all the very poor, all the sick in remote areas and all the Negroes in the South were given skilled nursing care.

Paul H. Fesler, president, American Hospital Association, in discussing "Hospital Nursing Costs and How They Are Met," said that the hospitals would be of more assistance to nursing education when they have been given standards to follow.

Dr. E. P. Lyon, University of Minnesota Medical School, in a paper before the league entitled "If I Were King" repeated his charges of hospital "racketeering" in the management of nursing schools. Hospitals are profiting to the extent of at least $16,000,000 annually at the expense of the unpaid student nurses, he declared. He recommended the elimination of the 2,000 nurses' training schools now in existence and the establishment of 200 new ones with proper curriculum and management.

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NEWS OF THE MONTH (Cont'd)

Economic Problems Outstanding on Western Program

"HOSPITAL Problems and the Economic Situation" will be the basic thought throughout the convention of the Western Hospital Association to be held in Salt Lake City, Utah, June 14, 15 and 16. Eminent speakers have been assigned subjects in line with this thought and a practical, helpful program is anticipated.

Each general session will be followed by a round table conference, when the various details of the subject matter presented at the general session will be considered at greater length.

The program, which is now completed, will open on Tuesday morning, June 14, with the registration of the delegates. Following this, an organ recital will be given in the famous Mormon Tabernacle. A business meeting will be held in the afternoon. It will be opened by Dr. B. W. Black, medical director, Highland Hospital, Oakland, Calif., president of the Western Hospital Association. Officers for the coming year will be elected.

A public meeting will be held in the evening, presided over by President Black. Louis Marcus, mayor, Salt Lake City, and George H. Dern, governor of Utah, will welcome the delegates in specially prepared addresses, to which G. W. Olson, superintendent, California Hospital, Los Angeles, will respond.

Dr. Malcolm T. MacEachern, director of hospital activities, American College of Surgeons, will sound the keynote of the remaining two-day program, on Wednesday morning, when he addresses the delegation on "Hospital Problems and Their Relationship to the Present Economic Conditions." Other speakers and their subjects will include: Carl Badger, attorney, Salt Lake City, "Patients for Whose Care the Public Is Responsible"; Matthew O. Foley, editorial director, *Hospital Management*, Chicago, "Emergency Care"; Jesse Budge, attorney, Salt Lake City, "Legislation Needed for the Good of Hospitals"; Dr. Charles W. Moots, representative of the American College of Surgeons, "Hospital Standards."

The afternoon session will be devoted to a study of nursing problems. Presiding over the meeting will be Carolyn Davis, superintendent, Good Samaritan Hospital, Portland, Ore. Speakers will include: Miss D. Dean Urch, superintendent of nurses, Highland Hospital, Oakland, Calif., G. W. Curtis, San Francisco, and Paul H. Fesler, president, American Hospital Association.

The annual banquet will be held in the evening, with President Black presiding. President Black will present his annual report, after which Dr. George H. Stephens, superintendent, Winnipeg General Hospital, president-elect, American Hospital Association, will give the address.

Departmental Problems to Be Discussed

The general subject for the third day's session will be "The Hospital and Its Departments." The address on this subject will be given by Dr. Bert W. Caldwell, executive secretary, American Hospital Association. "The Housekeeping Department and Purchasing" will be discussed by E. L. Slack, superintendent, Samuel Merritt Hospital, Oakland, Calif. Methods of obtaining and performing autopsies and their value as a teaching function of the hospital will be discussed by Dr. L. L. Daines, dean of medicine, University of Utah, Salt Lake City. Margaret Smith, Thomas D. Dee Memorial Hospital, Ogden, Utah, will speak on "Social Service in a Modern Hospital," and John A. McNamara, executive editor, THE MODERN HOSPITAL, Chicago, will present a paper on "Public Relations." This session will be followed by a round table.

At the closing session, John M. Pierce, research director, California Taxpayers' Association, Sacramento, Calif., will speak on "Simplified Modern Accounting," and will present a proposed plan to standardize hospital accounting. A public hospital section will be presided over by Dr. Charles E. Session, superintendent, San Diego County Hospital, San Diego, Calif. At the closing round table session, President Fesler will discuss "Future Policies of the American Hospital Association." The last formal address will be that by the Rev. John Edward Carver, pastor, Presbyterian Church, Ogden, Utah, on "Shall the Budget Balance?"

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NEWS OF THE MONTH (Cont'd)

Social Workers' Program to Stress Case Work Activities

The American Association of Hospital Social Workers will hold its fourteenth annual meeting at the time of the National Conference of Social Work in Philadelphia, May 16 to 21. The social case work activities of the medical social worker will be stressed in the program this year.

The general program will be opened on Monday, May 16, by the annual business meeting at which will be presented the annual reports and the general business of the association. On Tuesday afternoon Dr. Earl D. Bond, director, Institute of Mental Hygiene, Philadelphia, will preside at a meeting at which will be discussed "Medical Social Treatment." Edith Kruckenberg, supervisor, medical social work, Pennsylvania School of Social and Health Work, Philadelphia, will present the principal paper which will be discussed by Edith F. Eickhoff, director, social service, Indiana University School of Medicine and Hospitals, Indianapolis, and Edith Epler, director, social service, Syracuse Free Dispensary, Syracuse, N. Y. On Thursday afternoon there will be three group discussions on the following subjects: "Social Case Work Interviews in Their Settings—A Discussion of Place as a Factor in the Social Case Work Interview"; "Staff Education and Professional Development"; "Criteria for Selection of Social Cases."

Committee's Findings to Be Reviewed

A general meeting of special importance to medical social workers will be held on Friday. The subject, "Yesterday and Today—An Analysis of Medical Social Practice," will be discussed by members of the case competition committee who have during the past year reviewed the cases presented in all competitions. This year no new cases were called for, but the committee will report on the many interesting factors and trends as revealed in this large group of cases. Additional progress reports have been received since the records were presented. A study of all first award and honorable mention cases has been made.

There will be in addition several joint meetings with other groups, such as the National Tuberculosis Association and the National Society for the Prevention of Blindness. There will also be joint sessions with some of the sections of the National Conference of Social Work during the morning hours at which time the general conference meetings are scheduled.

Delegates will be entertained at tea at the Broomall Convalescent Hospital, Broomall, Pa. Dr. Joseph C. Doane, medical director, Jewish Hospital, Philadelphia, will preside at the annual dinner of the association.

An exhibit will be provided at the association booth in the auditorium where the meetings will be held. Members of the executive committee will be available for conferences. Opportunities to visit the Philadelphia hospitals will be arranged.

Ohio Endorses Movement for Chapman Memorial

A movement to honor the memory of the late Frank E. Chapman was initiated and met with warm support at the March meeting of the Ohio Hospital Association held in Akron. The following resolution was proposed and adopted:

WHEREAS there is a widely appreciated need for the better training of hospital administrators

WHEREAS one of the leaders in that movement, both in writing and in actual service was the late Frank E. Chapman

THEREFORE BE IT RESOLVED that the Ohio Hospital Association endorse the suggestion that a plan be developed for the training of hospital administrators to be named, "The Frank E. Chapman Memorial."

Be it further recommended that the trustees appoint a committee to secure the cooperation of those interested.

The proposal was that there be established an endowment fund of $10,000, contributed by the friends and associates of Mr. Chapman, which will constitute a revolving fund to assist students in hospital administration. The grant will be made to candidates selected by the committee, to assist them in financing their training at one of the group of hospitals that the committee will approve. The committee will consist of Rev. Maurice F. Griffin, Cleveland, Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, and Guy J. Clark, executive secretary, Cleveland Hospital Council, Cleveland.

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NEWS OF THE MONTH (Cont'd)

Canadian Nurses to Hold Biennial Meeting June 21-25

St. John, New Brunswick, is the city chosen for the biennial meeting of the Canadian Nurses Association which will be held June 21 to 25.

The central theme of the program will be the report of the Survey of Nursing Education in Canada. The Hon. Vincent Massey will discuss the report from the angle of the public, Prof. F. Clarke, McGill University, from the viewpoint of the educationist, Dr. G. Stewart Cameron, from the viewpoint of the medical profession, and Prof. Roy Fraser, Mt. Allison University, from the viewpoint of the scientist.

Salient features of the report to be considered at three general sessions are: recommendations regarding the approved training school, the cost of nursing education and nursing distribution.

Coming Meetings

American Association of Hospital Social Workers.
President, Elizabeth Wisner, Tulane University, New Orleans.
Executive secretary, Helen Beckley, 18 East Division Street, Chicago.
Next meeting, Philadelphia, May 14-21.

American College of Surgeons.
President, Dr. Allen B. Kanavel, 54 East Erie Street, Chicago.
Director general, Dr. Franklin H. Martin, 40 East Erie Street, Chicago.
Next meeting, St. Louis, October 17-21.

American Hospital Association.
President, Paul H. Fesler, Wesley Memorial Hospital, Chicago.
Executive secretary, Dr. Bert W. Caldwell, 18 East Division Street, Chicago.
Next meeting, Detroit, September 12-16.

American Medical Association.
President, Dr. Edward Starr Judd, Rochester, Minn.
Secretary, Dr. Olin West, 535 North Dearborn Street, Chicago.
Next meeting, New Orleans, May 9-13.

American Protestant Hospital Association.
President, Rev. A. O. Fonkalsrud, Mansfield General Hospital, Mansfield, Ohio.
Executive secretary, Dr. Frank C. English, Hyde Park, Station O, Cincinnati.
Next meeting, Detroit, September 9-12.

Association of Record Librarians of North America.
President, Maurine Wilson, Ravenswood Hospital, Chicago.
Secretary, Betty Gray, Nassau Hospital, Mineola, N. Y.
Next meeting, Detroit, September 12.

Catholic Hospital Association of the United States and Canada.
President, the Rev. Alphonse M. Schwitalla, S.J., Dean, St. Louis University Medical School, St. Louis.
Secretary, M. R. Kneifl, 1402 South Grand Blvd., St. Louis.
Next meeting, Villanova, Pa., June 21-24.

Colorado Hospital Association.
President, Frank J. Walter, St. Luke's Hospital, Denver.
Executive secretary, William S. McNary, University of Colorado School of Medicine and Hospital, Boulder.
Next meeting, Denver, June 10.

Connecticut Hospital Association.
President, Oliver H. Bartine, Bridgeport Hospital, Bridgeport.
Secretary, Maud E. Traver, General Hospital, New Britain.
Next meeting, Middletown, May 6.

Midwest Hospital Association.
President, E. Muriel Anscombe, Jewish Hospital, St. Louis.
Secretary, Walter J. Grolton, Missouri Pacific Hospital, St. Louis.
Next meeting, St. Louis, June 2-3.

Minnesota Hospital Association.
President, Dr. Fred G. Carter, Ancker Hospital, St. Paul.
Secretary-treasurer, James McNee, St. Luke's Hospital, Duluth.
Next meeting, St. Paul, May 23-25.

New Jersey Hospital Association.
President, Dr. George O'Hanlon, Jersey City Medical Center, Jersey City.
Executive secretary, Marie Louis, Muhlenberg Hospital, Plainfield.
Next meeting, Atlantic City, May 13-14.

Hospital Association of New York State.
President, Carl P. Wright, Syracuse General Hospital, Syracuse.
Secretary, Julian Funt, Beth Israel Hospital, New York City.
Next meeting, New York City, May 5-7.

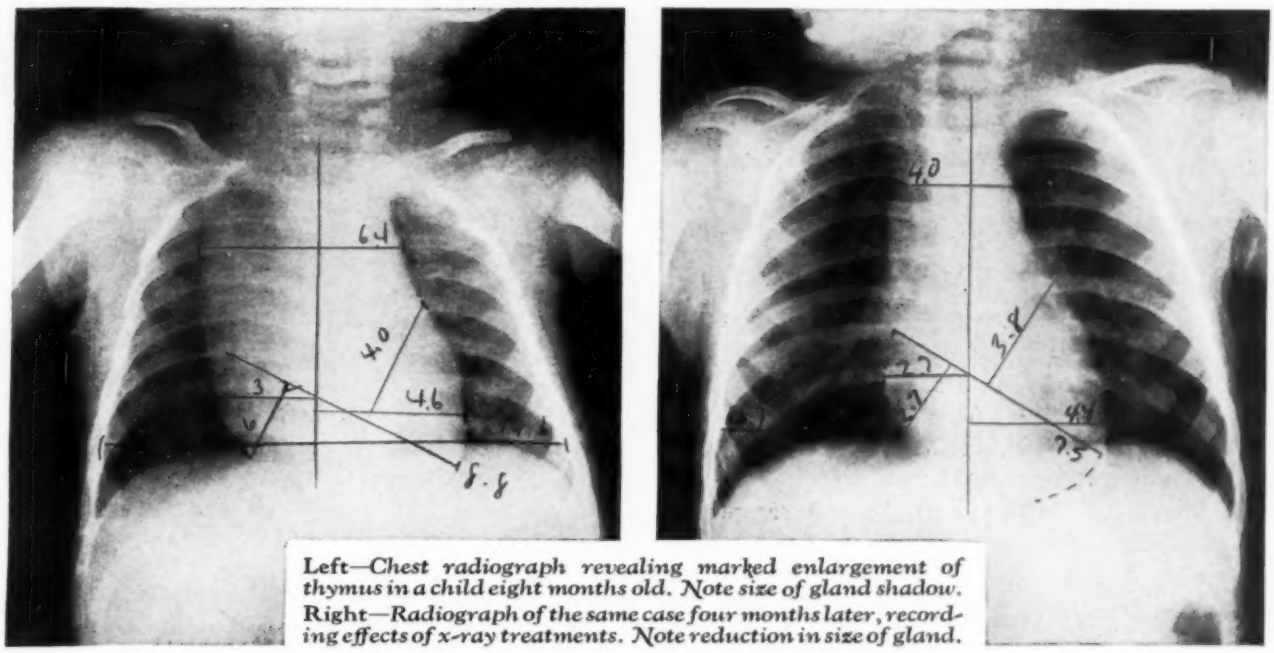
North Carolina, South Carolina and Virginia Hospital Associations.
Next meeting, Richmond, Va., May 17-19.

South Dakota State Hospital Association.
President, J. S. Harkness, Methodist State Hospital, Mitchell.
Secretary, C. W. Carlson, Moe Hospital, Sioux Falls.
Next meeting, Mitchell, June 7-8.

Western Hospital Association.
President, Dr. B. W. Black, Highland Hospital, Oakland, Calif.
Secretary, Mrs. L. M. Armstrong, Los Angeles.
Next meeting, Salt Lake City, Utah, June 14-16.

RADIOGRAPHS

protect the hospital against deaths due to *THYMUS HYPERPLASIA*



Left—Chest radiograph revealing marked enlargement of thymus in a child eight months old. Note size of gland shadow. Right—Radiograph of the same case four months later, recording effects of x-ray treatments. Note reduction in size of gland.

AMONG new-born infants, and children being operated on, undetected thymus hypertrophy frequently is a cause of sudden death.

Often, the condition gives no physical symptoms other than difficulty in breathing, and color change. Yet x-ray studies show that more than 7% of all infants have enlargement of the thymus gland necessitating x-ray treatment; that between 5% and 7% of children of adenoid and tonsil age show x-ray shadows suggestive of thymus hypertrophy.

Because radiography is the simplest and most economical way of detecting this condition in time to prevent sudden deaths, more and more hospitals are making thymus radiography a routine procedure.

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NEWS OF THE MONTH (Cont'd)

June 2 and 3 Chosen for Meeting of Midwest Association

THE Midwest Hospital Association, comprising the states of Colorado, Kansas, Missouri and Oklahoma, will hold its sixth annual meeting in St. Louis, June 2 and 3.

The officers of the association, as well as the various state executives, are making every effort to impress the members of the association with the importance of attending the annual meeting this year, stressing the point that at no time in the past has the individual hospital administrator so needed the stimulus of a convention as at present when he is confronted with problems of such paramount importance.

An interesting program has been arranged by the program committee, consisting of E. Muriel Anscombe, superintendent, Jewish Hospital, St. Louis, and president of the Midwest association, Dr. L. H. Burlingham, superintendent, Barnes Hospital, the Rev. R. D. S. Putney, superintendent, St. Luke's Hospital, Walter J. Grolton, superintendent, Missouri Pacific Hospital, and E. E. King, superintendent, Missouri Baptist Hospital, all of St. Louis.

Following the registration of delegates on the opening day, Miss Anscombe will preside at the first general session. Appearing on this program are Dr. Bert W. Caldwell, executive secretary, American Hospital Association, who will talk on geographic membership, and Dr. B. A. Wilkes, consultant for Baptist hospitals in Missouri, who will make "Some Suggestions to Meet Present Economic Conditions in Hospitals." Doctor Wilkes' talk will be discussed by Dr. G. W. Jones, Lawrence, Kan.

The presiding officer for the afternoon session will be Frank J. Walter, superintendent, St. Luke's Hospital, Denver, and president, Colorado Hospital Association. Appearing on this program are: Dr. Bert W. Caldwell, who will present a symposium on state laws that affect the hospitals comprising the Midwest Hospital Association; Dr. M. T. MacEachern, director of hospital activities, American College of Surgeons, Chicago, who will speak on "The Qualifications and Responsibilities of a Record Librarian"; J. P. Jacobs, credit manager, Missouri Baptist Hospital, St. Louis, who will speak on "An Experiment in Cooperative Collection of Hospital Accounts," and James A. Singer, a St. Louis lawyer, who will discuss Doctor Caldwell's paper.

The annual banquet and dance will be held in the evening with C. Rufus Rorem, associate for medical services, Julius Rosenwald Fund, Chicago, as the speaker.

Varied Topics Will Mark Second Session

A number of short speeches are scheduled for the second day. They will appear on the program in the following order:

"The Use of Civil Hospitals for Veterans," Paul H. Fesler, superintendent, Wesley Memorial Hospital, Chicago, and president, American Hospital Association; "The Importance of a Survey Preliminary to a Hospital Building Program," Matthew O. Foley, editorial director, *Hospital Management*, Chicago; Discussion, H. D. Smith, business manager, State University Hospital, and Oklahoma Hospital for Crippled Children, Oklahoma City; "Responsibilities of Boards of Trustees," John A. McNamara, executive editor, THE MODERN HOSPITAL, Chicago; Discussion, Aaron Waldheim, president, Jewish Hospital, St. Louis; "Graduate Nursing Service *Versus* Student Service in a Small Hospital," Dr. Rush E. Castelaw, Kansas City, Mo.; Discussion, From an Economic Viewpoint, W. J. Grolton, superintendent, Missouri Pacific Hospital, St. Louis; Discussion, From an Educational Viewpoint, Louis Hilligass, superintendent, University Hospitals, Columbia, Mo.; "Efficiency in Food Service," Mrs. Lee Shrader, dietitian, Barnes Hospital, St. Louis. Dr. G. W. Jones, Lawrence, Kan., will preside.

At the afternoon and closing session Phoebe Kandel, department of nursing education, Colorado State Teachers College, Greeley, will speak on "Standardization in Hospitals," and there will be a round table discussion conducted by Doctor MacEachern.

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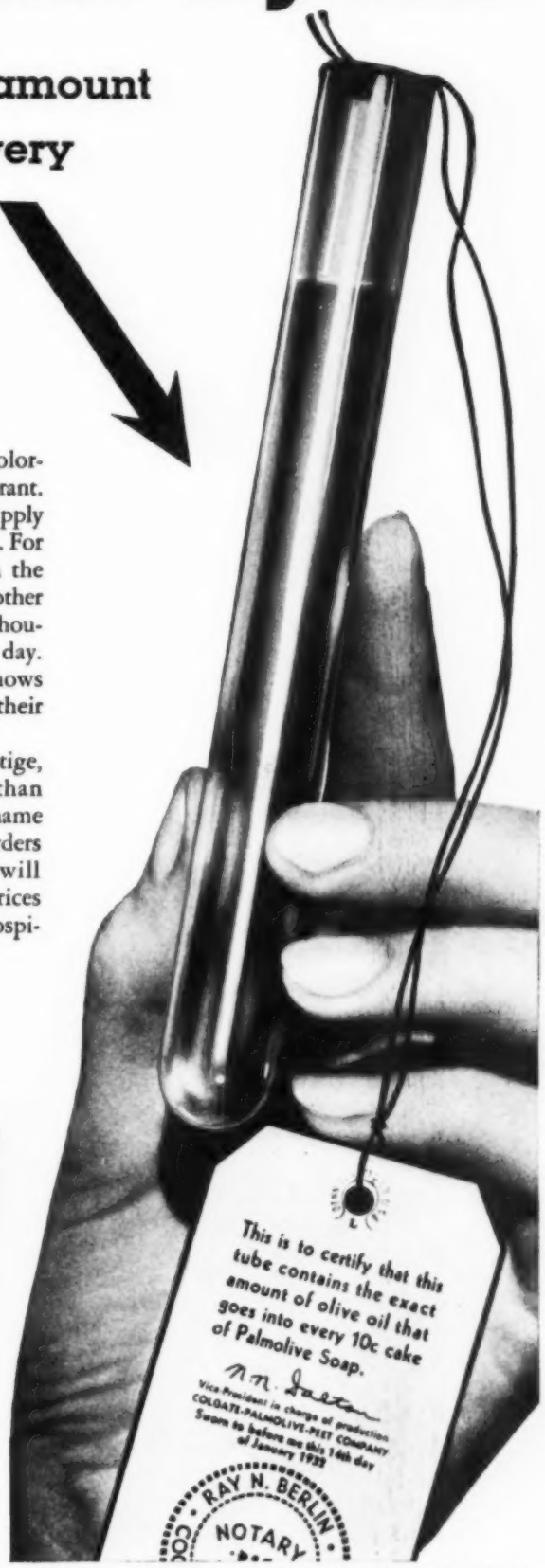
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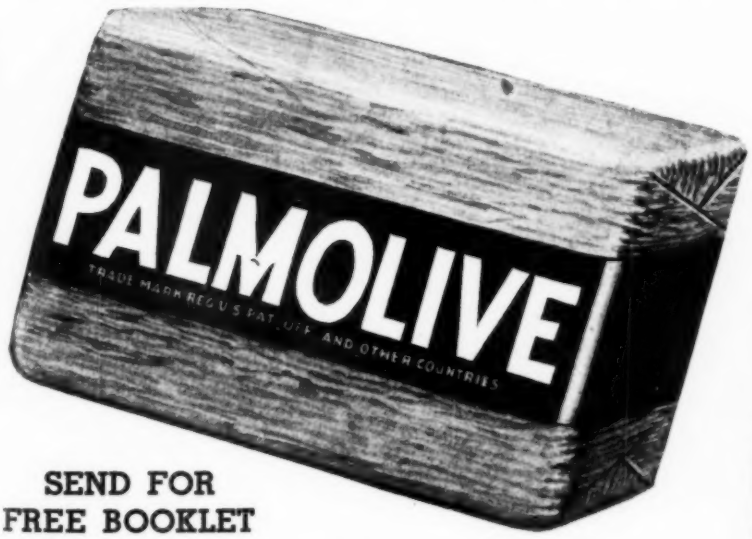

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NEWS OF THE MONTH (Cont'd)

Two Rochester Hospitals Benefit by Eastman Bequests

Rochester General Hospital and Genesee Hospital, Rochester, N. Y., were left $50,000 each by the terms of the will of George Eastman whose death by suicide was reported recently. Many philanthropic institutions of the city received similar bequests. The Rochester Community Chest will receive $100,000 for the first year following Mr. Eastman's death and $50,000 the second year, with no further provision made.

The University of Rochester receives the bulk of Mr. Eastman's estate valued at $20,000,000. A bequest of $1,000,000 was made to the Rochester Dental Dispensary. Through Mr. Eastman's generosity, a number of clinics have been or are being established abroad.

Hospital Celebrates Twenty-Five Years of Progress

The Hospital for Joint Diseases, New York City, celebrated its twenty-fifth anniversary with a clinical week, April 15 to 21.

In reviewing the history of the hospital, the printed program pointed out that 363,650 individual patients have been treated since it was founded, and that 2,686,934 visits to the out-patient department were made by patients in poor circumstances.

Patients cared for during 1931 numbered 5,462. The staff includes 305 physicians and surgeons, who took part in the clinical week exercises.

Mercy Hospital, Chicago, Buys Deep Therapy Unit of Million Volts

A million-volt deep therapy apparatus is shortly to be added to the equipment of the cancer clinic, Mercy Hospital, Chicago.

The clinic will then have an x-ray outfit capable of producing x-radiations of extreme intensity, emanating from a special x-ray tube which is energized with one million volts.

This will be the second installation of its kind in the world. The first was installed last fall in the New York Memorial Hospital, New York City. This equipment is said to deliver x-radiation the equivalent of that which emanates from many millions of dollars worth of radium.

Dr. Henry Schmitz is in charge of the cancer clinic at Mercy Hospital.

New York Inaugurates Program to Improve Welfare Services

A three-year program aiming to establish a statewide social intelligence service to make more effective the efforts of public welfare agencies was inaugurated in New York State on April 1, it has been announced by the State Department of Social Welfare.

This project will be conducted by the department's bureau of research, and involves the creation of facilities for currently assembling in the state department information on all phases of social welfare activity in the state. Systematically compiled and periodically dispatched to the bureau's Albany headquarters, these data are designed to provide a constant flow of dependable information covering progress and changes in public and private welfare operations.

In summarized and analyzed form, the results will show the taxpayer what use is being made of his contribution to the state's welfare budget, the total volume of such services, and the manner in which public and private agencies are sharing the cost. They will constitute a reference for the guidance and information of the legislature, public welfare administrators, social workers, directors of institutions, contributors to philanthropic enterprises and others whose interests are in any way connected with social welfare.

The scope of the study will include all the social welfare agencies coming within the purview of the Department of Welfare. Special attention will be directed first to the following fields: child care, including 154 institutions for dependent children, 100 temporary shelters for children, 90 child placing agencies; mothers' assistance, given through 48 boards of child welfare; children's courts; public outdoor relief given in 116 city and county districts; old age relief, 79 separate offices; public homes for the aged, of which there are 62 in the state, and hospitals, 300.

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NEWS OF THE MONTH (Cont'd)

Study on Costs of Federal and Civil Hospital Service Is Made

After an investigation of the comparative costs of service in federal and civil hospitals, C. Rufus Rorem, associate for medical services, Julius Rosenwald Fund, has presented his findings to the officers of the fund.

The summary of Mr. Rorem's study, which will be of interest to the hospital field at large, is given here.

"According to a resolution introduced into Congress by Representative McClintic of Oklahoma, it is proposed to permit the Veterans' Administration to provide medical services for veterans' illness or disability not connected with war service in local hospitals when beds in federal hospitals are not available. This plan has been submitted both as a measure of supposed economy for the government and in the interest of better medical care for the veteran since he would be in a hospital near his home and might have opportunity to select his physician personally. The conclusion of this report is that such legislation could not be supported as an economy measure.

Would Increase Demand for Hospitalization

"Its immediate effect would probably be to increase expenditures for medical care of veterans. It would undoubtedly increase the demand for hospital care of veterans at federal expense, since it is estimated that several times as many veterans are not treated for general medical and surgical conditions in nonfederal hospitals as are cared for in general hospitals of the Veterans' Bureau throughout the country.

"At present federal expenditure for medical care of veterans is about $50,000,000 annually, but this amount would probably exceed $100,000,000 if all veterans needing hospitalization were treated at government expense. The total expenditures of all kinds on behalf of veterans now exceed $500,000,000 annually, more than half being paid as compensation and pensions.

"The proposed legislation would probably not increase occupancy of nonfederal hospitals by more than a small percentage. It would, however, place the cost of hospital care and the professional fees for veterans upon the federal government rather than upon the veteran, his family, local taxes or private philanthropy.

"It would be necessary for the Veterans' Administration to select a limited number of nonfederal hospitals with which contracts would be made for such care and to make arrangements with physicians or medical societies for care of veterans in these hospitals at specified rates for various services. The medical profession would benefit financially by the use of local physicians who would receive these stated fees for services to veterans, regardless of their financial status. Probably most of the services to veterans, however, would be rendered by a limited group of physicians designated by the Veterans' Administration.

Why a Saving Would Not Be Effected

"Many of the federal hospitals for veterans have been built in small communities away from centers of population. Their sites have not been selected with a view to their sale or their disposal for utilization as civilian hospitals when the medical care of veterans has decreased in amount. In selecting sites for more veterans' hospitals for any class of cases, the federal government should consider the disposal value of the property.

"The expanded authority of the administrator of veterans' affairs, if granted by Congress, would probably have the effect of retarding construction of more veterans' hospitals by the federal government, although some new federal hospitals will doubtless be constructed for the care of mental and tuberculous cases. Over a period of thirty years the costs of new federal hospitals for general medical and surgical cases would probably not exceed 5 per cent of the total expenditures for medical care in case all veterans are provided services at government expense. As a device merely to avoid hospital construction, therefore, the proposed legislation would not involve a saving for the federal government.

Public Opinion Will Influence the Issue

"As to current expense, the comparative cost of the care of veterans in local, nonfederal hospitals as compared with their care in federal hospitals will be of secondary influence in determining decision upon the proposed legislation. What is to be done with regard to tax supported medical care for veterans (less than 4 per cent of the population) is a matter of public policy which will be determined by congressional action, influenced primarily by public opinion."

The diet of nervous cases

AN IMPORTANT physiological effect of caffeine is stimulation of the central nervous system—mainly on that part of the brain connected with psychical functions, producing a condition of wakefulness and increased mental activity. Caffeine, therefore, is contraindicated in the case of nervous persons, for whom both mental and physical *rest* are so important.

On the other hand, there is the psychological effect of a warm, stimulating drink which is conducive to sleep and affords a mental and physical sense of good cheer.

By habit and taste, the natural desire of most Americans chooses coffee as a mealtime beverage. Deprivation of coffee when a patient is already in an easily excitable condition, not only imposes an irritating restriction, but also deprives him of the beneficial effects of a hot drink.

In modern practice, both the physiological and psychological are balanced by prescribing for all cases of nervousness, a coffee without caffeine. In this way, the effects of caffeine are overcome with no loss of benefits of a warm and satisfying drink.

Kellogg's Kaffee Hag Coffee is free of caffeine effect. 97% of the caffeine is removed together with indigestible wax. Yet the full flavor of coffee is preserved with all its aroma and richness. It is particularly valuable in nervous cases, and may also be used in virtually every case where any nervous excitation might be harmful, as for pregnant women, for invalids and convalescents, and for people of advanced years.

A complimentary professional sample of "the coffee that lets you sleep" will be sent to you on request. Address Kellogg Company, Battle Creek, Michigan.

NEWS OF THE MONTH (Cont'd)

A. H. A. Asks Cooperation in Membership Drive

The American Hospital Association is appealing to the 2,850 potential institutional members in this country and Canada for membership support in the association.

In the appeal, which has already been mailed from headquarters of the American Hospital Association, it is pointed out that "there are approximately 7,000 hospitals in the United States and Canada. Of this number, 3,750 are Federal, state, county or city institutions, which have no appropriation for the payment of membership dues in any association. In addition, some 400 institutions are not eligible for membership in the association. There are 2,850 potential members of the association which should be enrolled in the institutional membership.

"The American Hospital Association has 1,504 institutional members in the United States and Canada. Obviously there is a need for every institutional member to cooperate with the membership committee in an intensive effort to interest hospitals that are not members to join.

"The objective of the membership committee is to enroll 250 new institutional members, 500 additional active and associate personal members and 100 additional life members."

All personal and institutional members are urged to take an active part in the drive.

Rhode Island Organizes Hospital Council

A Council of Hospital Superintendents for Rhode Island was organized on March 18, with the following officers chosen for the coming year: president, Carl A. Lindblad, director, Homeopathic Hospital of Rhode Island, Providence; vice-president, Dr. Harmon P. B. Jordan, superintendent, Providence Lying-in Hospital; secretary-treasurer, Charles M. Hoffman, superintendent, Miriam Hospital, Providence.

Other superintendents present at the organization meeting, which was held at Miriam Hospital, were: Dr. Arthur H. Ruggles, Butler Hospital; Dr. William O. Rice, Rhode Island Hospital; Dr. D. L. Richardson, Charles V. Chapin Hospital; Thomas E. Marsden, Hope Hospital, all of Providence; Walter E. Wright, Pawtucket Memorial Hospital, Pawtucket; John C. Gardner, Woonsocket Hospital, Woonsocket; Harry J. Dunham, Newport Hospital, Newport; Maud F. Denico, South County Hospital, Wakefield; Helen M. Blaidsdell, Westerly Hospital, Westerly; Blanche Peterson, Notre Dame Hospital, Central Falls; Dr. Harry L. Barnes, Rhode Island State Sanatorium, Wallum Lake.

Objects of the new organization are: cooperation among the administrators of the various hospitals in Rhode Island; the promotion and coordination of the work of the hospitals for the ultimate good of the individual patient and of the community; the promotion of economy and efficiency in hospital management; the development of participating relationships with the organized medical profession, the state and city authorities and the unofficial agencies.

Famous Old Chicago Hospital to Be Enlarged

The famous old ivy covered stone United States Marine Hospital on Clarendon Avenue, Chicago, is soon to be enriched by a half million dollar four-story addition. The addition is expected to be completed within ten months.

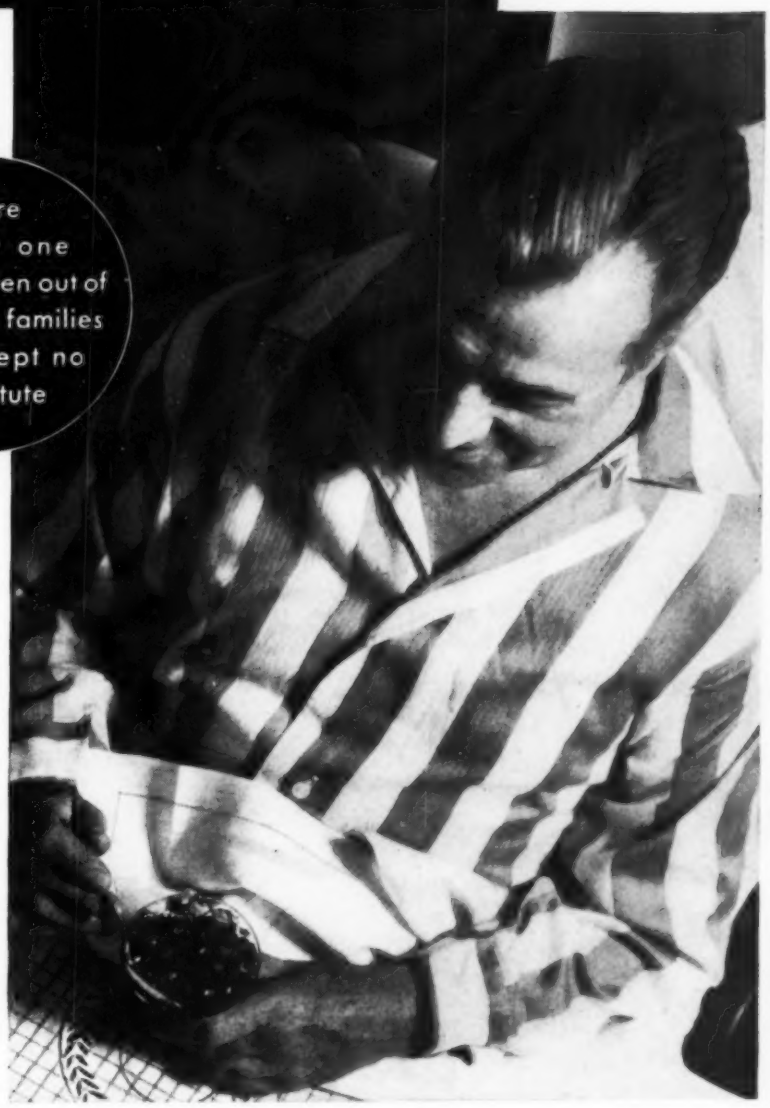
The new unit will be east of the old building and will be connected with it on each floor. It will have exterior walls of Lemont limestone, the same as the original structure. The roof will be flat, however, instead of mansard, as in the old building, and will be used as an open air solarium.

Additions and alterations are also to be made to the following structures on the eleven-acre grounds: the main hospital building; boiler house and laundry; a relocated garage building; attendants' quarters; nurses' and pharmacists' quarters, and junior medical officers' quarters.

The administrative offices and out-patient accommodations will be moved from the existing building to the first floor of the new unit. The second and third floors will be devoted to wards and rooms with a total of 250 beds. The entire fourth floor will be given over to operating rooms and a new x-ray department.

The officer in charge as head of the hospital is Dr. John W. Trask, medical director.

Six Pure Fruit Flavors In Interesting Combinations



There is only one Jell-O. Seven out of every ten families will accept no substitute

LET JELL-O, a pure, wholesome and delicious food, help you brighten the patient's tray with color and variety.

It can be done most economically, too.

The six pure fruit flavors of Jell-O offer, in themselves, various interesting combinations. For example, orange with lemon; lime with raspberry; lemon with raspberry, strawberry, or cherry.

Jell-O also combines excellently with small quantities of fruits and fruit juices left from other uses.

Other interesting changes in flavor and appearance can be obtained by whipping the Jell-O and folding in marshmallows, fresh fruits, or nuts.

Send today for an assortment of tested quantity recipes for new Jell-O desserts, salads, and variations. All are as easy to prepare as they are economical to serve.

FOR DIABETICS

You can safely let diabetics enjoy the pleasing variety of Jell-O by serving them D-Zerta, widely recommended by the medical profession for patients limited in their carbohydrate intake. The only difference between the two products is that D-Zerta is sweetened with saccharin instead of sugar.

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PERSONALS

EDGAR BLAKE, JR., recently assumed the superintendency of the Methodist Episcopal Hospital, Gary, Ind.

MISS JOHNNIE LETA HENRY is the new superintendent, Shawnee Municipal Hospital, Shawnee, Okla.

DR. JOHN C. RANDALL, superintendent, Cleveland Municipal Sanitarium, Cleveland, became superintendent, Pawling Sanitarium, Wynantskill, N. Y., on April 15, succeeding the former head of the institution, DR. LEO G. GUYER.

WORTH L. HOWARD of the Cleveland Welfare Federation has resigned to become an assistant director of the University Hospitals, Cleveland.

MRS. CLYDE NASON, who has been in charge of the Baker Hospital, Baker, Mont., for the last five years, is to take over the management of the new Hettinger Hospital, Hettinger, N. D., on June 1.

E. G. FULTON, business manager, Glendale Sanitarium and Hospital, Glendale, Calif., has accepted a position as manager and secretary-treasurer of the new Porter Sanitarium, Denver, Colo.

DR. PARLANE KINLOCH, principal medical officer, Scottish Department of Health, Edinburgh, died recently. DOCTOR KINLOCH, although only forty-six years old, was an outstanding figure in the field of public health.

HELEN M. OSTEN, surgical supervisor, Marietta Memorial Hospital, Marietta, Ohio, is the new superintendent at that hospital, taking the place of IRA J. DODGE, who has gone to the Huron Road Hospital, Cleveland.

DR. J. H. CURTIS has been chosen to head the newly completed Veterans' Administration Hospital, Wichita, Kan.

SIR HENRY WELLCOME, of American birth and well known for his scientific work and extensive researches in connection with tropical diseases, was recently elected an honorary fellow of the Royal College of Surgeons of England. SIR HENRY is a director of the Gorgas Memorial Institute, Washington, D. C., and founder of the Wellcome Tropical Research Laboratories at Khartoum, Africa.

B. EVANS PARRY, for many years director of the Canadian Government's Hospital Advisory Architectural Services, has recently formed a partnership with HAROLD J. SMITH, as practicing architects in Toronto.

DR. J. GOULD GARDINER, Columbia Clinic Hospital, Columbia, Miss., was elected president of the Mississippi Hospital Association at its annual meeting in Jackson, April 11. DR. J. C. CULLEY, superintendent, Oxford Hospital, Oxford, was chosen secretary-treasurer.

St. Luke's Is New Name of Woman's Hospital, Saginaw, Mich.

The Woman's Hospital, Saginaw, Mich., is now being operated by the Lutheran Inner Mission Society of Saginaw Valley, and the name of the hospital has been changed to St. Luke's. There has been no change in the personnel.

Illinois Hospital Gives Free Service to School Children

The Sterling Public Hospital, Sterling, Ill., admitted thirty-six school children on April 7 and removed their tonsils and adenoids, a service that was given without charge.

Martina C. Thode, superintendent of the hospital, points out that this work will take the place of the program planned for Hospital Day.

Jamaica Hospital Celebrates Its Fortieth Birthday

The Jamaica Hospital, Richmond Hill, N. Y., commemorated its fortieth anniversary on April 13 with a dinner dance at the Waldorf-Astoria Hotel, New York City. Some three hundred persons—trustees, medical staff and friends of the institution—were present.

Jamaica Hospital started as an institution of three beds, maintained by the women of the village of Jamaica. It was the only hospital in the community at that time. The present Jamaica Hospital is the outgrowth of that small beginning and continues to be a community hospital.

Every Tuesday and Thursday Night

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Joe Palooka is sent to you through the courtesy of Heinz Rice Flakes—"One of the 57 Varieties." Broadcast over a coast-to-coast hook-up of the Columbia Broadcasting System. Look for the time and station nearest you on the radio page of your newspaper—and listen in!

FOOD SERVICE AND EQUIPMENT

A Series by KATHERINE MITCHELL THOMA, Dietitian, AND HERMAN SMITH, M.D.,
Superintendent, Michael Reese Hospital, Chicago

Shall the Special Diet Kitchen Be Eliminated?

IN CLOSING this series of articles, we wish to discuss a method of handling therapeutic diets as a modification of the general hospital dietary. This is a development of the last few years which, because of its economic importance at the present time should perhaps be discussed more fully. Although one might be led to believe that this aspect of the work is entirely within the province of the dietitian, the administrator is definitely involved because of the economics of the situation and the administrative changes that must accompany this program.

When dietitians were first employed in hospitals. their two main functions were usually the teaching of dietetics to nurses and the administration of the diet kitchen where the diabetic and other special diets were prepared. We believe that it is still generally agreed that the preparation of weighed diabetic diets should be separated from the regular hospital dietary. In smaller organizations where the number of diabetic diets is not great, this might not be a necessity, but in larger organizations the involved nature of computing and preparing these weighed diets is more easily handled in a separate unit.

From the Old to the New

Attention to diets in those days was given only for those conditions for which special diet was a therapeutic measure. With the advances in the knowledge of nutrition, greater interest has been aroused in the normal adequate diet. At the same time, further study of the different corrective diets has shown that any therapeutic diet on which a patient is expected to live for an extended period of time must supply all the essential nutrients. It must meet insofar as possible the same nutritional requirements as an adequate normal diet.

Therapeutic diets need not be considered as separate units, but rather thought of as normal diets adapted to special conditions of certain diseases. This logical approach to therapeutic diets is clearly given in "Talks to Nurses on Dietetics" by Dr. Ruth Wheeler, professor of nutrition and physiology, Vassar College. Doctor Wheeler points out that in general all therapeutic diets fall into one of three definite categories: first, modification in consistency; second, modification in amount of one or more of the nutrients; third, modification of energy value.

Planning Around the General Diet

If we start with the premise that the general diet is planned to include all essential nutrients, it would seem to be the logical basis for all therapeutic diets. Most hospital systems must have a full diet and a soft or light diet. When these menus are properly planned they contain practically all the foods needed for all the therapeutic diets. The supplementary foods which must be added can easily be cared for in the main kitchen.

The accompanying menus for a day show what modifications of the general menus are necessary for some typical special diets. It may thus be seen how the menus for therapeutic diets can be modifications of the general diet. The next logical step is, of course, actually to make the modification of the general diet in the main kitchen and eliminate the special diet kitchen.

The elimination of the special diet kitchen has many obvious economic advantages, the details of which need not be discussed further. It seems to be a peculiar milestone of progress that the place in which dietitians first found an opportunity to work in the hospital is now the place we would eliminate.

The elimination of the special diet kitchen is a practical procedure and does not work any hard-

Quantity Production brings down the Cost of

THIS PRACTICAL COMBINATION BOWL *by Gorham*

WITH COVER 014748

BOWL ONLY 014747

WITH COLLAR 014747
for "supreme" liner

WITH COLLAR 014749
for Delmonico glass

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The design is Early American in feeling; but this is the kind of a bowl that would be useful with your service.

With its cover, it can be used for soups and cereals . . . without the cover, it is an ideal holder for grapefruit, melon or other halved fruits . . . with its collar for Delmonico glass, for serving orange juice, tomato juice or clam juice . . . with collar to hold "supreme" liner, for fruit or seafood cocktails, bouillon, ice cream.

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The construction is Gorham quality nickel silver base (not less than 18 per cent) heavily silver plated. *No soft metal or soft solder is used in the construction of Gorham hospital ware.* Write for new catalogue just issued.

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BREAKFAST

Full	*Convalescent* No red meats No coarse cellulose No fried foods	*Obesity* Low calory	*High Caloric*	*Anemia* High iron High vitamin High Nucleated proteins	*Restricted Protein*	*Gastric Ulcer* 6 small meals 10-12 oz. each	
Sliced orange	Orange juice	Sliced orange	Sliced orange	Sliced orange	Sliced orange	Strained orange juice	3 oz.
Oatmeal	Oatmeal	.....	Oatmeal	Oatmeal	Oatmeal	Strained oatmeal	3 oz.
Bacon	.....	.....	Bacon	Bacon	.....	.....	
Egg	Egg	Egg	Egg	Egg	Egg	Egg	2 oz.
Toast	Toast	Toast—1 slice	Toast	Toast	Toast	Toast	1 slice
Butter	Butter	.....	Extra butter	Butter	Butter	Butter	
Cream	Cream	.....	Extra cream	Cream	Cream	Cream	3 oz.
Coffee	Coffee	Coffee	Cocoa	Coffee	?	.....	
Midmorning	.....	.....	Orange juice and lactose	Orange juice		Milk Cream Custard	3 oz. 3 oz. 4 oz.

DINNER

Consommé vegetables	Cream of pea soup	Consommé	Cream of pea soup	Consommé	Strained cream of pea soup	Cream of pea soup	4 oz.
Roast prime ribs of beef au jus	Baked chicken and noodles	Roast prime ribs of beef au jus	Baked chicken and noodles	Roast prime ribs of beef au jus	.....	.....	
Mashed potato	Mashed potato	.....	Mashed potato	Mashed potato	Mashed potato	Mashed potato	3 oz.
Buttered cauliflower	Purée fresh spinach	Cauliflower and spinach	Cauliflower	Spinach large serving	Cauliflower and spinach	Spinach purée	3 oz
Spring vegetable salad	.....	Spring vegetable salad large serving	Spring vegetable salad	Spring vegetable salad	Spring vegetable salad large serving	.....	
Bread	Bread	.....	Bread	Bread	Bread—1 slice	Toast	1 oz.
Butter	Butter	.....	Extra butter	Butter	Butter	Butter	
Caramel custard	Caramel custard	Baked apple	Custard and cream	Caramel custard	Baked apple	Custard	3 oz.
Tea	Tea	Tea	Tea	Tea	.....	.....	
3 P.M.	.....	.....	Chocolate malted milk	Eggnog		Milk Cream Gelatin	3 oz. 3 oz. 4 oz.

SUPPER

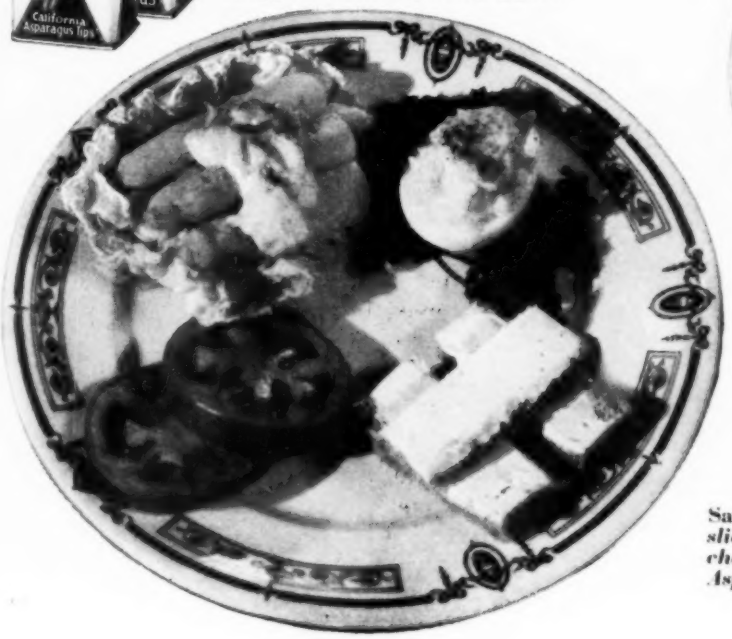
Broiled ham, pineapple glacé	Omelet	Omelet	Broiled ham, pineapple glacé	Broiled liver	Omelet small serving	Omelet	3 oz.
Baked sweet potato	Baked sweet potato	.....	Baked sweet potato	Baked sweet potato	Baked sweet potato	Small baked potato	
Fresh green beans	Purée of peas	Fresh green beans	Fresh green beans	Fresh green beans	Fresh green beans	.....	
Watercress	.....	Watercress	Watercress	Watercress	Watercress	.....	
Bread	Bread	.....	Bread	Bread	Bread	Toast	1 slice
Butter	Butter	.....	Extra butter	Butter	Butter	Butter	
Milk or cocoa	Milk or cocoa	Skim milk	Milk—half cream	Milk or cocoa	Milk or cocoa	Milk Cream	3 oz. 3 oz.
Rhubarb sauce	Rhubarb sauce	Rhubarb sauce	Rhubarb sauce	Rhubarb sauce	Rhubarb sauce	.....	
9 P.M.	.....	.....	Hot chocolate	.....	.....	Milk Cream Strained apple-sauce Crackers	3 oz. 3 oz. 3 oz. 1 oz.

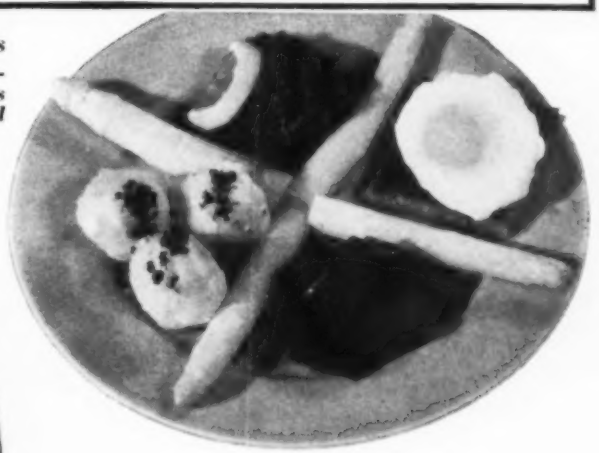
IF patients could run your kitchen

They'd choose dishes like these!

For Anti-Constipation and Diabetic Diets

Asparagus Vinaigrette. *Arrange Libby's Asparagus Tips on lettuce. Garnish with half slices of tomato. Serve with French dressing, and chopped chive or green pepper.*





For the Meat-Free Diet

Vegetable Plate. *Divide a plate into quarter sections with Libby's Asparagus (Stalks). In these—place a poached egg on toast, cubed buttered beets, spinach and parsley potatoes.*

For Private Room Supper

Salad Sandwich Plate. *Arrange on plate 3 finger-slices of whole wheat bread spread with creamed cheese, 2 slices tomato, ½ devilled egg, and 4 Libby's Asparagus Tips on lettuce topped with mayonnaise.*

A QUEER idea, certainly . . . patients in charge of your diet kitchen. They'd probably break every single dietetic rule.

But you could be sure of one thing, couldn't you? They'd pick the dishes with flavor, color, looks.

So why not serve them what they ought to have, and what they *want?* Dishes dietetically correct *and* as good to eat as these?

No question about it, they'll make a hit . . . with patients, because they're so attractive . . . with you, because all three can be served at a moderate portion cost.

And when you're preparing them, be sure to use this superb asparagus of Libby's!

For, in Libby's Asparagus, you have wonderfully tender, creamy white stalks only—with the true, delicate flavor of new-cut asparagus. All alike in size and shape. Packed full count to every can.

Order Libby's Asparagus—Stalks or Tips—from your usual source, today. Bear in mind, too, that Libby packs numerous other fine food products, listed at the left, expressly for hospital use.

Libby's 100 Foods

These Libby Foods of finest flavor are now packed in regular and special sizes for institutions:

Red Raspberries	Tomato Juice	Salmon
Tomato Purée	Olives, Pickles	Evaporated Milk
Corn, Beets	Mustard	Mince Meat
Hawaiian Pineapple	Bouillon Cubes	Boneless Chicken
California Fruits	Beef Extract	Stringless Beans
Spinach, Kraut	Peas	Santa Clara Prunes in Syrup
Jams, Jellies	Catchup	Strawberries
Pork and Beans	Chili Sauce	

Loganberries California Asparagus

Libby, McNeill & Libby
Dept. N-36, Welfare Bldg., Chicago

ships on an organization. A few of the larger hospitals have closed their diet kitchens and find that they get along well without them. Others are beginning to consider the idea. In the present economic stringency it is suggested that organizations might consider looking into this aspect of their dietary organization carefully.

Valuable Lessons for Student Nurses

Objection may be made to the fact that the handling of the special diets as modifications of the general diet in the main kitchen would deprive the student nurses of the valuable instruction they formerly received in the special diet kitchen. It is our belief that the handling of special diets, as a modification of the general diet, will offer more in the way of instruction to student nurses than the previous method because it crystallizes in their minds the fact that all diets must be adequate and that special diets are merely a modification of the normal adequate diet.

It should be noted that the routine we have outlined could be carried out with any degree of fullness and efficiency only in organizations where the dietitian has charge of the food in the main kitchen.

In our series of articles we have attempted to cover the functions of a dietary department in the hospital in various degrees of detail. Some of the aspects of the problem were touched upon sketchily; others were given considerably more attention. Throughout the series purely technical problems of nutrition were omitted, and only those that were of common interest to both dietitians and administrators were discussed.

The Series Summarized

In closing this series, we merely wish to stress some of the points we outlined in previous articles:

1. The hospital as represented by its governing board and the administrator should decide the type of food service it wishes to give to its patients and personnel in the various categories in the hospital. This means a definite budgetary allowance.

2. The administrator should transmit this information directly and concisely to the dietitian.

3. The dietitian and the administrator should work out detailed methods for carrying out the desires of the governing board of the hospital.

4. The dietitian should be given complete charge of food preparation and distribution and held definitely responsible for this service.

5. The dietitian and administrator should keep in close contact with their joint problems in order that the initial program can be carried out efficiently and that current changes can be adopted as needed.

How One Civilian Hospital Works With the Veterans' Bureau

"How One Hospital Enjoys a Satisfactory Agreement With the Veterans' Bureau to Care for Former Soldiers," is the subject of an article in the *Western Hospital Review* for March. The hospital in question is Compton Sanitarium and Las Campanas Hospital, Compton, Calif.

"In 1920, Compton Sanitarium made a contract with the U. S. Public Health Service for the care and treatment of neuropsychiatric former service men and women. Later this contract was made with the U. S. Veterans' Bureau, when the bureau assumed the responsibility for the medical care and treatment of veterans, and has continued to the present time. A similar contract for general medical and surgical patients was made between the Veterans' Bureau and Las Campanas Hospital.

"The hospital now has contracts with the bureau to provide forty beds for male and twenty beds for female patients. A patient is admitted to the hospital on the presentation of a card of admission provided by the bureau. The general procedure of care and treatment is that of a patient in any good general hospital. In addition to the standard hospital records, a report is made to the bureau on a special form soon after admission, reports are made thereafter when indicated by the patient's condition or when required by bureau regulations, and always a report is made again to the bureau upon the final disposition of the case.

"Compton Sanitarium has a contract with the bureau to provide forty beds for neuropsychiatric women. Since the opening of the U. S. Veterans' Hospital, Palo Alto, Calif., in 1927, neuropsychiatric men have been hospitalized at that hospital. Through certain provisions of a neuropsychiatric contract with the bureau, male neuropsychiatric beneficiaries of the bureau whose disabilities have been connected with service origin (and who accordingly receive compensation pay), may be given a card of admission for emergency treatment, pending the availability of a bed at a Governmental hospital.

"Essentially no distinction in housing, care or treatment is made between charges of the Veterans' Bureau and private patients of Compton Sanitarium or Las Campanas Hospital. A flat daily rate is paid by the bureau for hospitalization, the same for general medical and surgical patients as for neuropsychiatric patients, higher than the average general hospital charge for a ward bed without the usual extra charges, probably lower than the average general hospital charge for a ward bed plus the usual charge for medicine."

Relieve Constipation this Natural Way *pleasantly and efficiently*

RY-KRISP Whole Rye Wafers do double duty in diets planned to relieve constipation, by increasing both the efficiency and the palatability of the diet! For the convenience of those who direct diets —we list the specific advantages derived from Ry-Krisp Whole Rye Wafers as a natural aid in relieving constipation:

1 Ry-Krisp carries a high percentage of bran, valuable in mechanically stimulating the mucous membranes of the stomach and intestines—increasing secretion and peristalsis.

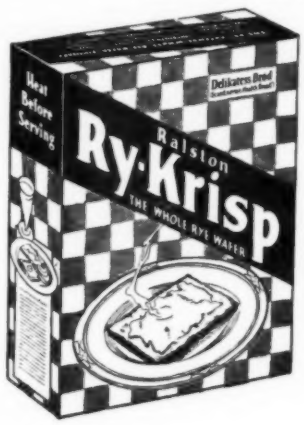
2 Its pentosan content is twice that of whole wheat.

3 Its crude fiber content is high, for it is a natural whole grain wafer, containing no added ingredients other than salt.

4 Its very low moisture content gives Ry-Krisp an exceedingly high absorbing power—and makes it a particularly effective bran carrier.

5 Its phytates, containing calcium, phosphorus, magnesium and potassium, are a natural aid in producing normal bowel action.

Patients of any age welcome Ry-Krisp Whole Rye Wafers because of their extreme versatility. Crisp, crunchy, and decidedly unusual in flavor, these whole rye wafers are equally popular with breakfast, lunch or dinner—with as wide a variety of foods as the diet permits. May we send you further data on Ry-Krisp, and samples for testing? Fill in the coupon or attach it to one of your letterheads.



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Without obligation, please send me your complete Research Report on Ry-Krisp and a supply for testing.

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HOSPITAL EQUIPMENT AND OPERATION

Conducted by C. W. MUNGER, M.D.
Director, Grasslands Hospital, Valhalla, N. Y.

New Types of Oxygen Tents Have Many Desirable Features

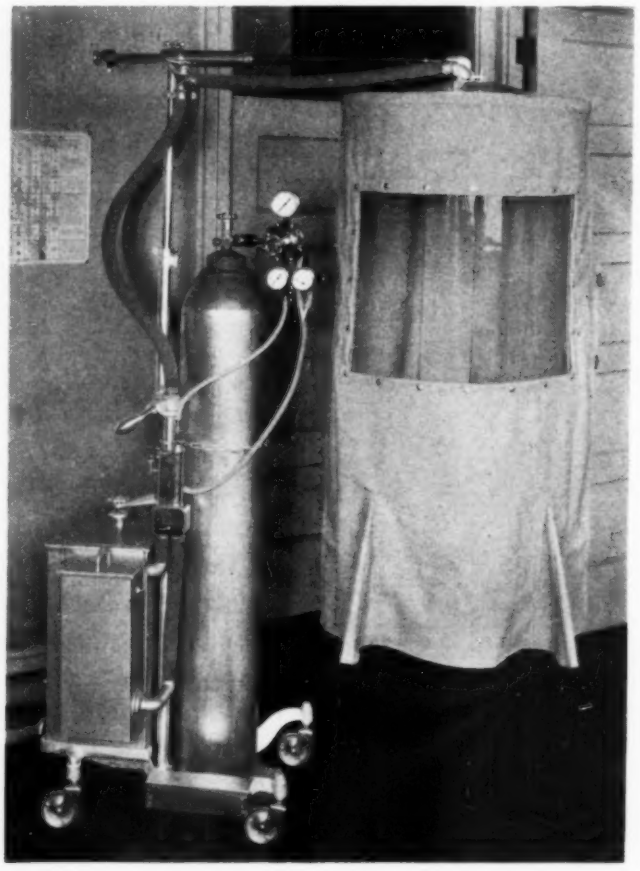
THE use of oxygen therapy, not as a last resort, but as an invaluable aid in the early treatment and permanent relief of anoxemia resulting from acute pulmonary edema, coronary thrombosis, cardiac decompensation, pneumonia and many other causes, makes oxygen therapy equipment increasingly valuable for the hospital.

In the selection of this equipment, a number of outstanding essential features should be considered and demanded. Adequate, properly controlled circulation, ample refrigeration and maintenance of the proper humidity of the oxygen-rich air to be breathed are the essential requirements upon which the patient's welfare depends. The oxygen therapy apparatus should operate silently, be accurate in its deliveries and dependable in its functioning. Its operation should be simple, and it should be adaptable to varying conditions.

Two new oxygen tents, one a motorless and the other a fan type, have been designed with these desirable features in mind. The two types are identical except that an automatic air syphon is used on the one, and a motor blower unit is used on the other to produce circulation.

It is a single movable outfit with the gas tanks and ice chest included as part of the unit so that the equipment is ready for instant use. It may be wheeled into position, adjusted, and the mechanism operated by any nurse. Even the large oxygen tanks can be replaced without lifting them by the use of a tank truck. The tent hood may be easily adjusted in the proper position regardless of the height of the bed or its location in the room. The window may be independently faced in any direction, and free access to every part of the apparatus, and an unobstructed passageway between the apparatus and the bed maintained. The small amount of floor space (22 by 28 inches) occupied by the entire outfit makes it possible to use this apparatus in cramped quarters.

Circulation of the oxygenated air is provided by a large, safe, totally enclosed, quiet and cool running universal motor blower unit that is under rheostat control. Flexibility of circulation control is achieved by the rheostat so that a gradually increased volume may be built up to more than



The motorless oxygen tent.

A NEW DAY DAWNS FOR MODERN ANTISEPSIS

LYSOL NOW

The fight against virulent infectious germs goes on . . . with redoubled vigor!

Modern antiseptic practice is now enriched with a new double-strength "Lysol" . . . A "Lysol" with a phenol coefficient of 5, while ordinary cresylic preparations give one-half or less of this value . . . A "Lysol" that searches out and kills death-dealing germs in half the time . . . A "Lysol" that cuts to an absolute minimum the cost of hospital disinfection.

And here is more great news! . . . This new double-strength "Lysol" is available to hospitals at the same no-profit-price that prevailed on the old "Lysol" . . . $1.50 a gallon in lots of ten gallons or more.

No longer need reliable disinfection be a hospital problem. No longer need be tolerated those cheap, unsafe, weak substitutes.

Get your order in early . . . Hospitals come first . . . They must be supplied before any commercial announcement is made of this radically new "Lysol" . . . Use the coupon.

TWICE AS STRONG
. . . in phenol coefficient

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TWICE AS QUICK
. . . in germicidal action

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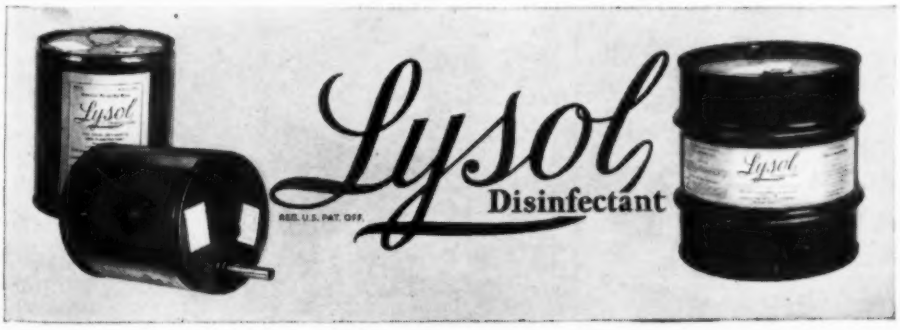
SAME PRICE
$1.50 PER GALLON
in lots of 10 gallons or more



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Bloomfield, N. J.

Will you kindly ship immediately..... gallons of the new double-strength "Lysol" disinfectant.

Your name and title_____

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Your hospital_____

City_____ State_____

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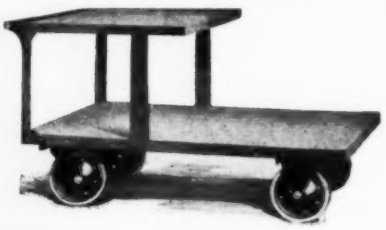
A real labor saver in carrying large containers about the kitchen. Upper deck level with top of stoves and steamers. Model 6073 Kitchen Truck.



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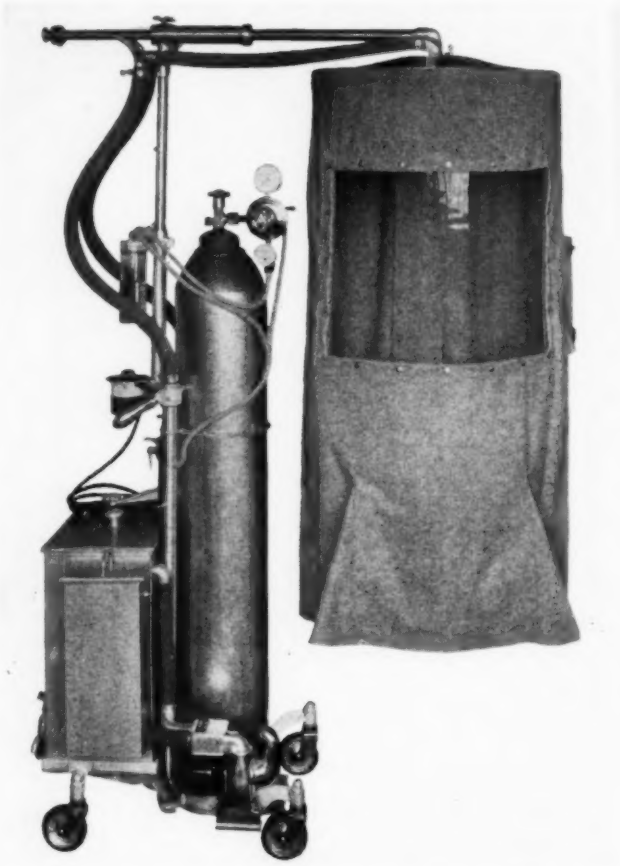
HOSPITAL EQUIPMENT
SURGICAL, FOOD SERVICE, FURNITURE

double the normal requirement, but circulation cannot be reduced to an uncomfortable limit. The oxygen supply is under automatic regulation, is accurately measured and indicated in quantities as desired, from 1 to 15 liters a minute. In addition an auxiliary valve is provided through which from 50 to 60 per cent oxygen concentration may be built up within the tent hood in a few seconds. Fifty per cent relative humidity is automatically maintained by passing all the air-oxygen circulation through the ice chest, thereby precipitating moisture sufficient to obtain the prescribed low humidity even with the lower circulation volumes. The ice chest has a sufficient capacity to last from eight to twelve hours in rooms of normal temperature.



The motor blower type of oxygen tent.

Safeguards have been applied to ensure a constant oxygen supply. The oxymeter regulating device is protected against gauge and diaphragm breakage by an automatic safety valve which functions to release damaging pressures and thereafter automatically closes. Tubings are so constructed and supported that danger of kinking is eliminated. They enter the tent hood through the dome of the hood where no patient can obstruct them either with the arm or the bedding. The dome has a rotatable rim to which the rubberized tent hood is attached. This hood expands to an eleven-foot circumference. The delirious patient

Undoubtedly one of the strangest of all orders connected with the development of nursing and hospitalization was the Brothers of Mercy, founded in Florence about 1250. First organized among porters to act as stretcher bearers during intercity wars they soon attracted men of all ranks who served constantly in peace or war.

An entirely volunteer organization they were pledged to be ready at all times to drop their tasks or pleasures, don their strange robes and answer any call for help.

Their weird costumes might well strike terror in the hearts of the uninitiate. But they gained such a reputation for gentleness and skill that they were welcome wherever sickness or suffering existed.

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DRINKER RESPIRATOR

SIMPLIFIED OPERATION

The New Drinker Respirator is extremely simple to operate. All controls are grouped together for convenience. The cot can be raised or lowered from the outside. Opening and closing takes only 3 seconds. Hand operation is accomplished without effort.

INCREASED COMFORT AND BENEFIT

The New Drinker Respirator is silent in operation. There is no vibration. There is provision for head elevation. Increased sanitation measures. Both positive and negative pressures are now available. Any respiration speed from 14 to 32 can be obtained quickly.

REDUCED PRICE

Standardized design, efficient construction methods, plus the greater production due to the increased demand for Drinker Respirators, allow us to reduce the price of this pre-proved life saving device to $1500.

A new circular describing the New Drinker Respirator with its 20 improvements is ready for you.

Write for the NEW CIRCULAR

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Without obligation send me the new circular describing in detail the New Drinker Respirator's 20 improvements.

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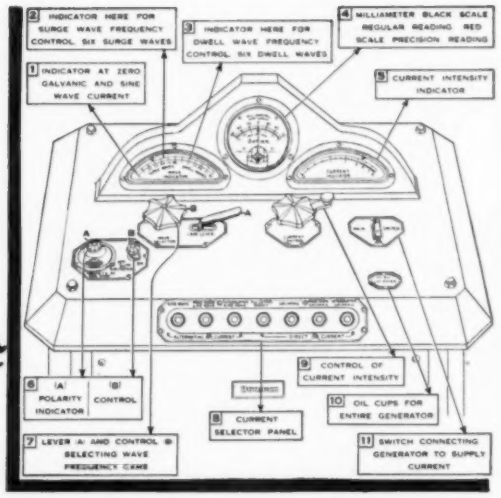
Study This Diagram


2 INDICATOR HERE FOR SURGE WAVE FREQUENCY CONTROL SIX SURGE WAVES
3 INDICATOR HERE FOR DWELL WAVE FREQUENCY CONTROL SIX DWELL WAVES
4 MILLIAMETER BLACK SCALE REGULAR READING RED SCALE PRECISION READING
1 INDICATOR AT ZERO GALVANIC AND SINE WAVE CURRENT
5 CURRENT INTENSITY INDICATOR
9 CONTROL OF CURRENT INTENSITY
6 (A) POLARITY INDICATOR (B) CONTROL
10 OIL CUPS FOR ENTIRE GENERATOR
8 CURRENT SELECTOR PANEL
7 LEVER A AND CONTROL B SELECTING WAVE FREQUENCY DIAL
11 SWITCH CONNECTING GENERATOR TO SUPPLY CURRENT

Precision and Accuracy of Control

with the new Burdick Morse Wave Generator

Careful study of the above illustration reveals the many refinements which caused six New York City hospitals to install Burdick Morse Wave Generators in December, 1931. You will not err in following New York in its approval of this simple yet most effective means of producing *Mechanical, Physical* and *Chemical* changes in pathological tissue. For complete data and proofs of advantages, write to

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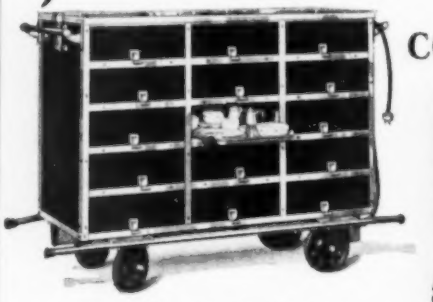
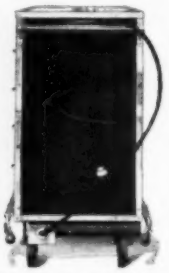
Burdick PHYSICAL THERAPY EQUIPMENT

The MUIRDALE TRAY CONVEYOR



Side view showing one compartment open.



End view showing cord which is detached when conveyor is in use.

THE hospital or sanatorium equipped with Muirdale Tray Conveyors can serve as high as 350 bed patients per hour from one kitchen with greater savings because:

1. Muirdales eliminate auxiliary diet kitchens.
2. Muirdales make possible complete supervision of all trays by the head dietitian.
3. Muirdales release for additional beds that space formerly occupied by such auxiliary diet kitchens.
4. Muirdales deliver food to patients at precisely the proper temperature and in its most palatable form because of moist heat which preserves flavor and prevents food from drying out.
5. Muirdales reduce cost by elimination of breakage, extra labor, and waste.

Our Engineering Department will assist you in planning the rearrangement of your present equipment or any additional improvements. Write us regarding your food problems. Our services are free and do not obligate you in any way.

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cannot pull the tent fabric off the aluminum dome because this strain is compensated by the method of dome suspension. Pull on the fabric merely results in tipping the dome which is automatically self-righting when the strain is released.

Soda lime is used for the removal of excessive carbon dioxide. The capacity of the container is from 8½ to 9 pounds, which is sufficient for twenty-four hours of continuous use. The soda lime basket is removable for cleaning or refilling, and for drying the soda lime to prolong its usefulness. A flip of a lever brings the soda lime in or out of the oxygen circulation, and makes possible the change of baskets without interrupting operation. An auxiliary tank of carbon dioxide makes it possible for this gas to be administered with the same machine should such treatment be indicated. An independent means is provided for delivering this gas in measured, indicated amounts that are under automatic regulation.

Two Concealed Door Checks for Interior Doors

Two overhead concealed door checks based on different mechanical principles have recently been designed for installation on interior doors. The advantage of this type of door closer is the elimination of all exposed mechanism with its dirt catching surfaces, and in rooms with a special architectural treatment no mechanical closing device need be exposed to mar the beauty of the room.

The first overhead concealed door check was particularly designed for hollow metal doors, and can be applied to any metal door having a pocket space of 1⅜ by 3⅞ inches within the hinge and head stiles. It is recommended that steel reenforcing plates be welded at the corner of the door where the closer is applied to give additional strength to the door.

This door check may also be applied to wood doors by means of side plates that are given the same finish as the woodwork. The door stiles should be at least 1¾ by 4½ inches in size.

The check is nonhanded and will allow the door to open 150 degrees unless set back in a deep reveal. If a 180-degree opening is desired, a special handed arm is supplied. The closing of the door is regulated by two valves, one for closing speed from 90 to 20 degrees, and the other for the last 20 degrees. The second valve is important in preventing drafts or wind moving the door slightly when it is not latched. A safety relief valve prevents damage to the door or the check when either is under unusual strain.

The spring tube, which is enclosed in the hinge stile of the door, has a cap at the bottom which

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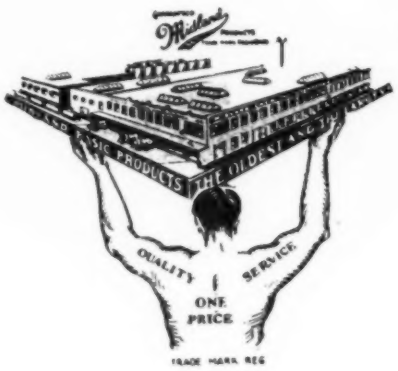
IN these times when it is too tempting to cut corners here and there, to skimp on this and save on that, the Midland Laboratories have held firmly to their original policy of QUALITY FIRST. Rest assured that every Midland Product that you buy today is of the same standard of purity and uniformity as it always has been and so long as we make it » » it always will be.



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WBBM—Chicago	WAAB—Boston	WDRC—Hartford
WCCO—Minneapolis	WCAO—Baltimore	WSPD—Toledo
WCAU—Phila.	WXYZ—Detroit	WOWO—Ft. Wayne

HORLICK'S :: RACINE, WIS.

can be removed for adjusting the spring to take care of any unusual conditions that may develop. The latch and closing speed adjustments are on the back edge of the stile, and are easily accessible for regulation.

This check is also adaptable to center-pivoted doors and gates by means of special arms and pivots.

The second concealed door closer was also designed for application on metal doors, although it may be applied to wood doors provided they are

In this illustration is shown the concealed door check installed in a hollow metal door. All mechanism with its dirt catching surfaces has been concealed.

at least 1¾ inches thick and have a top rail of at least 6 inches in depth. Metal side plates are necessary unless the door is 2 inches or more in thickness, when the closer may be mortised into the door like a lock.

The closer is composed of two compression springs applying their power to the spindle by means of two racks, with the racks so arranged that the turning force is balanced, thereby reducing the side pressure on the shaft bearings. A high grade mineral oil is used in the hydraulic checking cylinder to assure continuous lubrication, and to enable the closer to control doors that are subject to strong drafts.

These closers will work through 180 degrees, the first valve controlling the door action up to the last five or six degrees. The second valve controls the action of the last degrees so that it may be possible either to release or tighten the control when the door is subjected to a draft condition, giving either a silent or release action. Two regulating screws on top of the closer control the adjustment. There is no hold open feature made for this device, and it is also necessary to specify whether it should be right or left-hand.

MAXIMUM AND UNVARYING POTENCY...

Armour's Pituitary Liquid

(U.S.P.X.)

THE posterior lobe of the hypophysis cerebri of cattle is used in the preparation of Armour's Pituitary Liquid (U. S. P. X.). The Armour Laboratories have almost an unlimited supply of fresh, raw material to draw upon for their glandular products and other organotherapeutic preparations. In the Armour Packing Plant more than 16,000,000 head of cattle are slaughtered yearly. This permits the most cautious selection of glands.

The material for all Armour organotherapeutic preparations is processed immediately—as it comes warm from the killing floor. This immediate processing is almost exclusive with Armour. Maximum and unvarying potency is thus insured. In more than thirty years' service, preparing medical supplies of animal origin, not one product of the Armour Laboratories has been found wanting in potency. In the use of Armour's Pituitary Liquid (U. S. P. X.) uniform therapeutic activity is assured.

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Armour's Surgical Ligatures, produced in the Armour Laboratory, are prepared under modern, scientific conditions. They are sterile . . . of uniform strength . . . absorb evenly into the living tissue. In all standard types and sizes. Send for samples.

Armour's Pituitary Liquid (U. S. P. X.) is useful in overcoming intestinal paresis after abdominal operations. It has a pronounced effect upon the muscular coat of the intestinal tract. Used as a routine after abdominal operations it causes the patient to void urine and stimulates peristalsis, thus facilitating the expulsion of gas and avoiding the administration of morphine.

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Simply apply it with a cloth—no rubbing required. It colors the surface scratches—dries quickly—produces a lustrous, permanent coating far more protective than the original finish. It is also ideal for use on woodwork and for waterproofing and preserving wall decorations. As a means of sealing the pores of wood, concrete or terrazzo floors to make them easily cleanable, it is far superior to wax, lacquer or any other material on the market.

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A Metal Dinner Plate That Keeps Food Hot

Keeping food hot while it is being transported to the patient is one of the annoying problems of food service in the hospital.

A metal dinner plate with a reservoir beneath for hot water is one of the devices that may be used to help keep food hot until it is eaten. The reservoir is easily filled by removing the metal cap and placing the dish beneath the hot water tap.

The plate is shown here with the three-compartment well in place.

The plates are 8⅝ inches in diameter and may be had with a single or three-compartment well. A plate cover that may be used with these plates also helps to keep the food hot.

These plates are made from nickel silver base that is 18 per cent or better, and plated with a heavy deposit of pure silver. No soft metal or soft solder is used in their construction.

Providing Thermostatic Control in the Hospital

The thermostatic radiator valve has definitely brought into heating a new type of control that should be considered for hospital heating. While this type of control has not the same sensitivity that pneumatic and electric systems possess, it still is capable of accurate and gradual regulation, and it is an economical system to install. The thermostatic valve may be applied to any type of radiator, unit heater or unit ventilator.

The thermostatic radiator valve is a self-operating regulator that is designed to control the temperature of rooms heated by direct, indirect or concealed radiation of the vacuum or vapor type of heating systems. The device consists of a diaphragm operating valve connected by flexible tubing to a thermostat which can be obtained in two styles, the bulb and the wall types. For exposed or concealed radiators, the bulb type of thermostat should be used when there is sufficient room to place it under the radiator. It should be in a central position, but should never be nearer the floor or radiator than 2½ inches.

When it is not possible to place the bulb type properly, the wall type of thermostat should be

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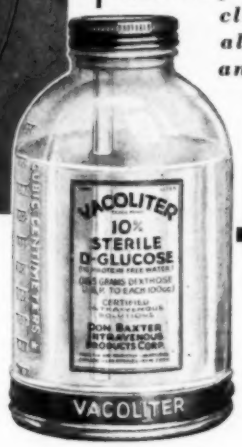

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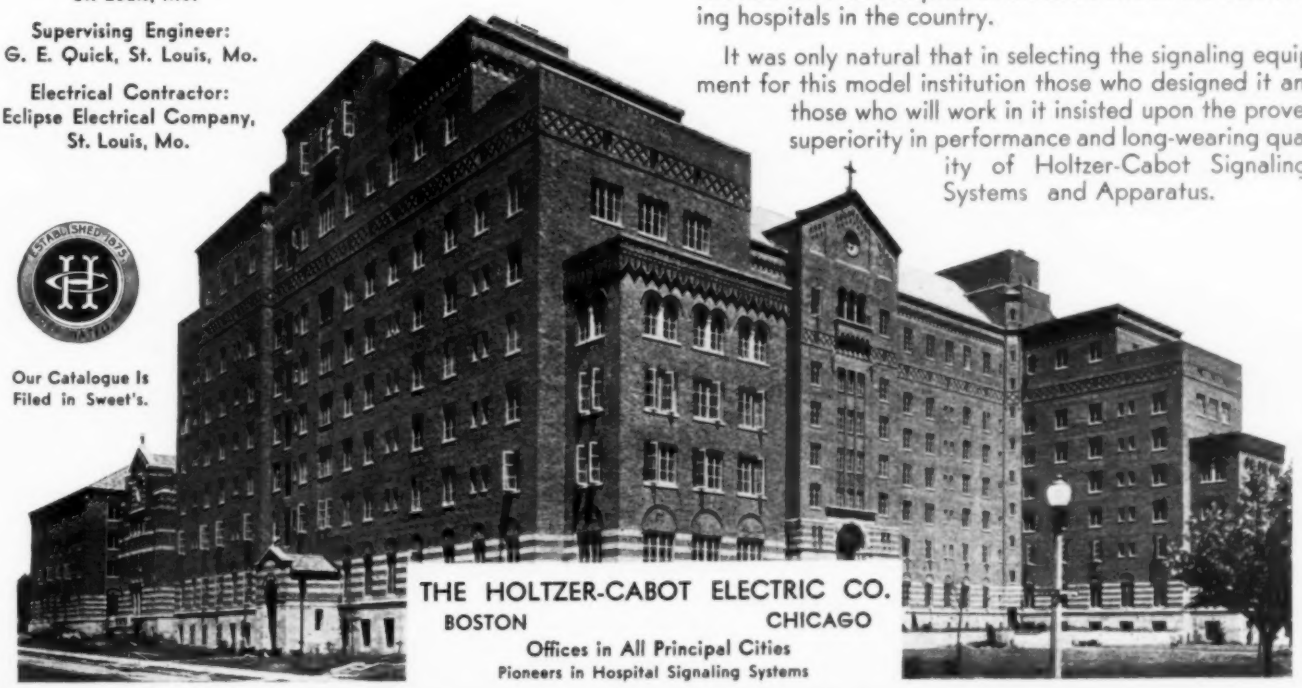

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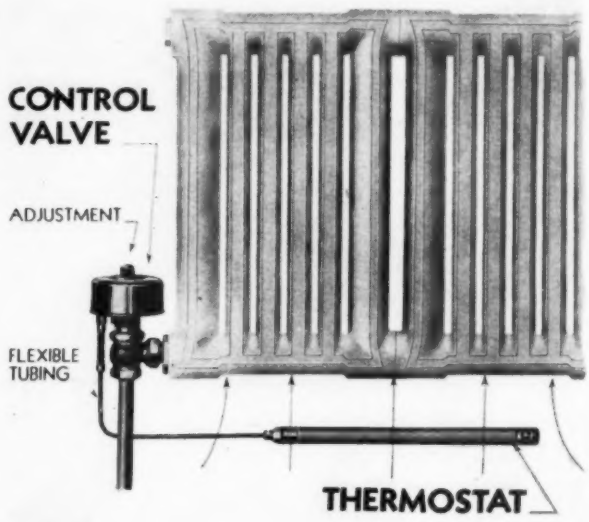
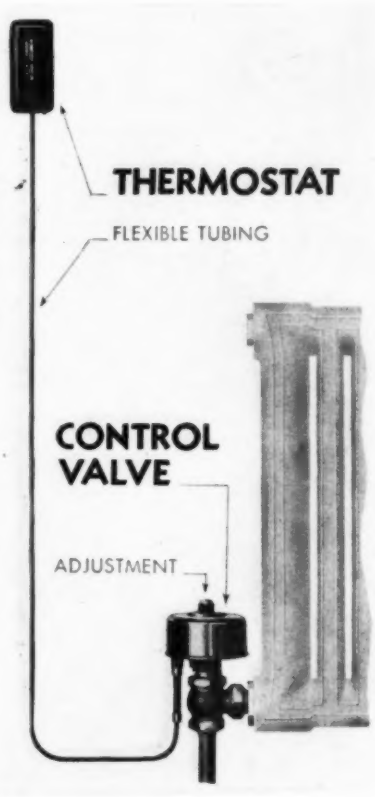
used. It should be mounted on the wall or window casing 24 to 48 inches above the floor, but never directly above the radiator. The bulb type of thermostat is recommended for the unit heater and unit ventilator.

The thermostat is connected to the radiator





The bulb type of thermostat attached to the radiator control valve is shown in the upper picture. In the illustration at the right is the wall type of thermostat attached to a radiator control valve.

valve by flexible copper tubing, and contains a sensitive fluid which expands and generates a pressure due to the heat of the atmosphere surrounding it. This pressure is communicated through the flexible tubing to the diaphragm of the valve, either opening or closing the valve to maintain the desired room temperature. Great accuracy of temperature control is obtained by large sensitive

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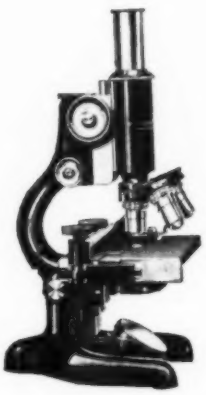

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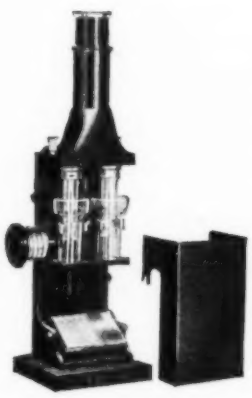

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